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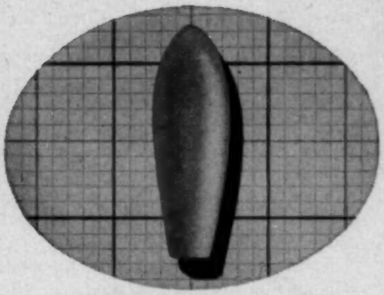

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# Between Ourselves

*In the sixteen months* since she took office as general secretary of the Canadian Nurses' Association, **M. Pearl Stiver**, our guest editor this month, has successfully learned the art of living out of a suitcase. It is probable that few nurses realize what a mileage is amassed in the course of a year by our ***National Office personnel*** as they make their visits to the annual meetings of the provincial associations, attend committee meetings, or officially represent our national association at formal affairs.

One of the very salutary results of these frequent contacts with the members in their own communities is the vastly increased interest in and awareness of the problems confronting our profession that is shared by nurses from coast to coast. In the years to come this growth of professional consciousness will continue to expand as Miss Stiver and the others at National Office move among us, talk to us, write for us. You will enjoy Miss Stiver's comments.

* * *

*This month we conclude* the lengthy series of articles on the various aspects of ***Civil Defence*** of special concern to the medical and nursing professions. As we noted when the series began last June, this is a most useful and comprehensive coverage of the possible exigencies that may arise. We recommended then that each nurse should clip the articles out as they were published and keep them together in a special folder. We earnestly hope you may never have occasion to use any of the information for defence purposes but with equal fervor we trust that everyone has prepared herself against a possible calamity. New methods may be instituted as the years pass but this basic information is sound and comprehensive. We shall always be grateful to the Canadian Medical Association and its *Journal* for having enabled us to make all of this information available.

* * *

**Mr. R. D. McLean,** *public relations officer* in the Department of Economic Affairs of the Alberta Government, is assisting us to acquaint you with our hostess province for the ***C.N.A. Biennial Convention*** next June by securing suitable authors to bring to life the history of Alberta. **H. Dempsey's** story reveals how very short a time it is since Alberta was the land "where the buffalo roam." Succeeding issues will carry other aspects of this interesting story.

* * *

*Several subscribers* have written us endorsing the opinions Rhoda F. MacDonald expressed in her November article — ***I may be old-fashioned but . . .*** C. S. said, "It tickled my interest. It does express so much of what we older nurses feel . . . Personally, I feel many of us older nurses could show a better example!" P. D. wrote at greater length: "At the risk of being classified by that opprobious epithet 'old-fashioned,' may I say how heartily I endorse the article. Although inactive for some time I have had constant contact with graduate and student nurses and feel strongly that the maturity of at least two years of university should be required if student nurses are to cope successfully with their theoretical education and their nursing duties.

"The young nursing student of today is not lacking in idealism but credits are necessary to pass exams and too often the pressure of studies crowd out the true spirit of nursing.

"I would not for a moment decry the need of nursing education but would not a survey of registries reveal that the requests from both doctors and patients are preponderantly in favor of the old-fashioned nurse who, perhaps less academically brilliant, has that necessary understanding that enables her to minister to her patients' bodily needs and whole personality? Such a survey might help to furnish guidance for those charged with the difficult task of planning curricula.

*"Let us make time to nurse.* Don't let us hand over the most rewarding and soul-satisfying part of our profession to nursing aides, leaving the bare bones of theory, clerical work,. and technical achievement to the R.N.'s."

* * *

*The change in the title* of the ***section prepared by our National Office*** was made just before the January issue went to press — too late for comment here. We feel it is a more appropriate caption for the lively pieces of information that appear each month.

**"For a dry skin,** Noxzema is just wonderful," says Pauline Margraf. "It prevents winter flakiness and keeps my skin soft."

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Now wash it off—yes, *wash* it with a cloth wrung out in warm water. Noxzema is a fluffy cream, not a greasy one. How *fresh* your skin feels—*how clean it is!* Do this every night and every morning. And use *greaseless* Noxzema as your night cream.

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# New Products

*Edited by* DEAN F. N. HUGHES

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## ICTOTEST

**Manufacturer**—Ames Company of Canada Ltd., Toronto.

**Description**—A tablet method for the detection of urine bilirubin.

**Indications**—For the early detection of infectious hepatitis and jaundice.

**Administration**—Five drops of urine are placed on test mat. One tablet is placed in centre of moistened area; two drops of water are flowed on top of tablet. If positive, test mat turns purple around the tablet. Reading is taken in 30 seconds.

## PEDESED

**Manufacturer**—Canada Pharmacal Co. Ltd., London, Ont.

**Description**—Stable, non-aqueous preparation containing in each cc.: Phenobarbital 13.4 mg.; pentobarbital sodium 6.7 mg.; homatropine methylbromide 6.7 mg. in a palatable liquid chocolate base.

**Indications**—For sedation of infants and small children.

**Administration**—Infants up to one year, 5 to 10 drops, placed directly on the tongue. For older children, adjust dosage for age, weight, and condition of patient.

## PRANTAL with Phenobarbital

**Manufacturer**—Schering Corporation Limited, Montreal.

**Description**—Prantal with phenobarbital contains 100 mg. of Diphenmethanil methylsulfate and 16 mg. (¼ gr.) phenobarbital in a sugar-coated tablet.

**Action**—Anticholinergic agent plus the mild sedative action of phenobarbital.

**Administration**—Dosage should be individualized. Usual dosage is one or two tablets every four to six hours.

## RAUDIXIN

**Manufacturer**—E. R. Squibb & Sons of Canada Limited, Montreal.

**Description**—Tablets prepared from the whole root of *Rauwolfia serpentina*. Uniformity is controlled by animal assay. Acts on the central nervous system. Onset is gradual. It is mildly laxative and mildly sedative. May cause nasal congestion. It lowers arterial blood pressure and slows pulse rate.

**Indications**—For oral treatment of mild and moderate hypertension, in conjunction with other hypotensive agents in more severe cases.

Maintenance therapy after combined treatment has lowered high blood pressure. There are no dangerous reactions and few if any unpleasant ones. Pressure does not fluctuate, critical adjustment of dosage is unnecessary, and tolerance to its action is unreported.

**Administration**—Usual dosage is 4 to 8 tablets daily divided morning and evening.

## RUBIGUENT

**Manufacturer**—John Wyeth & Brother (Canada) Limited, Walkerville, Ont.

**Description**—Formula: Histamine dihydrochloride 0.1%; methyl nicotinate 1.0%; glycol monosalicylate 10.0%; capsicum oleoresin 0.1%, in a bland cosmetic base.

**Indications**—Provides analgesic, decongestive, and spasmolytic properties; beneficial for symptomatic relief of muscular aches, pains and stiffness associated with muscle strains, arthritis, neuritis, sprains, fibrositis, and fatigue. It is an adjunct in physical rehabilitation following immobilization for fractures and other disorders. Application to the neck and chest will often relieve the symptoms in bronchitis and certain other respiratory conditions.

Methyl nicotinate has the ability to penetrate the skin and muscle tissue rapidly, carrying with it the other active agents which diffuse to relieve congestion, disturbed circulation, pressure, and pain.

**Administration**—Apply freely to affected areas and rub lightly until the cream vanishes. Do not bandage. Repeat one to three times daily as needed.

*Note:* Do not use on inflamed or broken skin, nor in contact with mucous membranes.

## SNAKE POISON ANTITOXIN

**Manufacturer**—Pinheiros Institute, Brazil. *Can. Dist.:* Earl H. Maynard, Weston, Ontario.

**Description**—A combination of various snake poisons as an antidote in a 10 cc. glass ampoule packaged with capillaries for sensitivity test prior to inoculation.

**Indications**—An antidote against snake bite.

**Administration**—One full 10 cc. vial injected intramuscularly. Repeat if necessary.

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### BECOBARB TABLETS

**Manufacturer**— Frank W. Horner Limited, Montreal.

**Description**—Each tablet contains: Phenobarbital ¼ gr.; thiamine 2 mg.; riboflavin 0.5 mg.; pyridoxine 0.2 mg.; niacinamide 10 mg.; calcium d-pantothenate 1 mg.; brewers' yeast 64 mg.

**Indications**—Where B-complex seems advisable in conjunction with prolonged sedative therapy. Particularly valuable for the edgy, tense, and anorexic patient.

**Administration**—One or two tablets daily, or as prescribed by physician.

### BINAEMON

**Manufacturer**—Organon (Canada) Limited, Montreal.

**Description**—Each tablet contains: Bifacton (vitamin $B_{12}$ with intrinsic factor concentrate) ⅙ U.S.P. Unit; folic acid 0.8 mg.; ferrous sulfate exsiccated 133 mg.; vitamin C 50 mg.; liver concentrate 100 mg.

**Indications**—A wide spectrum hematinic; may be prescribed for any form of anemia: hypochromic, microcytic, macrocytic, normocytic or pernicious.

**Administration**—For most anemia patients, 3 tablets per day. In severe cases, including macrocytic anemia of pregnancy, 6 tablets per day. In pernicious anemia, 9 tablets per day.

### CARDALIN Tablets

**Manufacturer**—Irwin, Neisler & Company, Decatur, Ill. *Can. Dist.:* Herdt & Charton, Inc., Montreal.

**Description**—Aminophylline 5 gr. with anti-nausea factors: aluminum hydroxide 2.5 gr. and ethyl aminobenzoate ½ gr.

**Indications**—Angina pectoris, coronary thrombosis, myocardial infarction.

**Administration**—Three to 6 tablets daily.

### CO-ELORINE

**Manufacturer**—Eli Lilly and Company (Canada) Limited, Toronto.

**Description**—Each pulvule contains: 'Amytal' (Amobarbital, Lilly) 8 mg. (⅛ gr.); 1-cyclohexyl-1-phenyl-3-pyrrolidino-1-propanol methsulfate 25 mg. (⅜ gr.)

Co-Elorine is an effective parasympathetic blocking agent with the advantage of negligible side effects at the therapeutic dosage level. It also exerts a sedative action, which is frequently desirable in patients requiring this type of therapy.

For the treatment of spasm and hypermotility of the gastrointestinal tract and for use as an adjunct to peptic ulcer therapy. Especially indicated in conditions affecting the gastrointestinal tract in which spasm is a prominent factor, since these conditions are often aggravated by emotional disturbances or nervous tension — e.g., pylorospasm, gastritis, peptic ulcer, irritable colon, spastic colitis, mucous colitis, regional ileitis, ulcerative colitis.

**Administration**—Average dosage 1 or 2 pulvules, two or three times daily.

### DOLOMIDE COMPOUND

**Manufacturer**—Charles E. Frosst & Company, Montreal.

**Description**—Each tablet contains: Salicylamide 5 gr.; phenacetin 2 gr.; caffeine citrate ¼ gr.

**Indications**—Acute rheumatic fever, rheumatoid arthritis, and in patients who are sensitive to or cannot tolerate the common salicylates.

**Administration**—One to four tablets, one to four times daily as required.

### HYDROMBRINE 106

**Manufacturer**—Dagra Ltd., Diemen, Holland. *Can. Dist.:* Fidelity Pharmaceutical Co., Hamilton, Ont.

**Description**—Homogeneous, highly viscous, all but colorless, sterile, aqueous, 106% w/v solution of the methylglucamine salt of 3:5 diiodo-4-pyridone-N-acetic acid, which contains 42.3% iodine; a contrast medium for use in bronchography possessing low toxicity and providing clear contrast, correct rate of filling of bronchial tree, rapid absorption and excretion.

**Indications**—Bronchography.

**Administration**—In adults, 20 ml. generally suffices following recommended procedure. No bronchography should be performed in case of poor general health, far advanced kidney degeneration, or bronchial asthma, and preferably not in acute bronchopneumonia. Possible hypersensitivity to iodine may be ascertained by oral administration, one day in advance, of 500 mg. potassium iodide in water.

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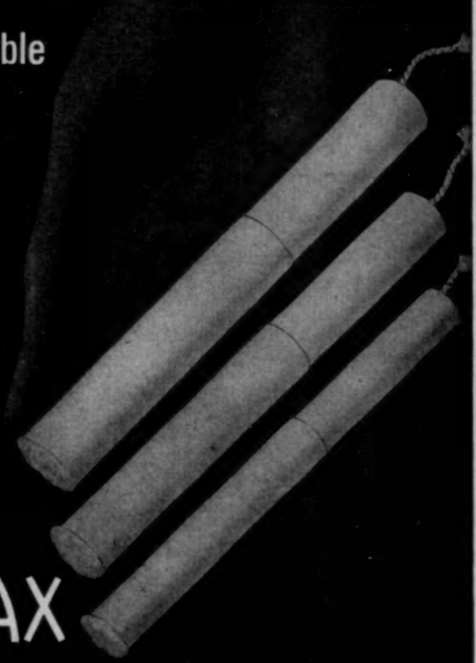
Goodwill flows irresistibly to the man who successfully manages his own affairs, who is self-reliant and independent, yet who is considerate always of the rights and needs of others.

— THOMAS E. DEWEY



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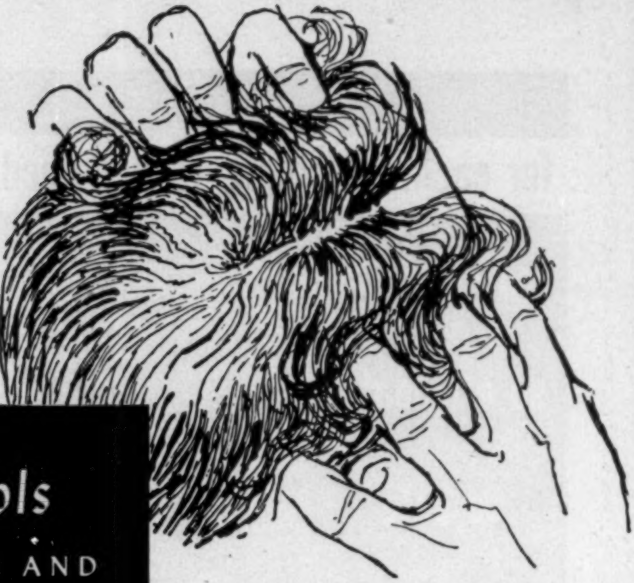

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1. Slepyan, A. H. (1952), Arch. Dermat. & Syph., 65:228, February.
2. Slinger, W. N., and Hubbard, D. M. (1951), *ibid.*, 64:41, July
3. Sauer, G. C. (1952), J. Missouri M.A., 49:911, November.

THE CANADIAN NURSE

*L'Infirmière Canadienne*

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 50 NUMBER 2

MONTREAL, FEBRUARY, 1954

# This Great Association — OURS

SELFISH or unselfish — I suppose everyone of us is naturally most concerned with those things which come closest to us and which affect us personally. We think and say that the C.N.A. is our Association. May we not go further and say, "We are the C.N.A.!" We the nurses, the people, the pieces which go together to make up the great mosaic — the Canadian Nurses' Association.

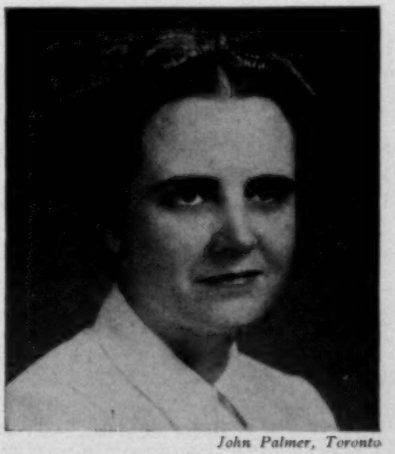
A great Association, this C.N.A.! Great in so many ways — in numbers, in tradition, in scope, in future!

Well, how many of us are there? At this moment of writing 33,050 — one in every 447 citizens of our country, .2 per cent of our country's total population.

Look at it another way. The C.N.A. represents 1/5 of the membership of the American Nurses' Association in a country of 1/10 the population of the U.S.A. — 33,050 of us representing, we say it modestly, the finest in Canadian womanhood.

Now, let us speculate on what would happen if each one of us, each of the 33,050, were "red hot" members of the C.N.A.? Certainly the general public would be well educated with respect to nursing and nursing problems. One doubts if there would be difficulty in securing assistance for nursing education. When John Q. Public gets behind a program, it has to go. Nothing can stop it! Wonder what would happen to recruitment if every adolescent realized the numerous opportunities awaiting him or her in so many fields of nursing!

And what would happen in our own



John Palmer, Toronto

PEARL STIVER

Association? If everyone of us were "on fire" for the C.N.A., would any Registered Nurse in our country dare not to be a member? Would anyone, much less a nurse, not know what the C.N.A. is doing? Informed, with clear thought and open mind, each would pass comment on program and planning.

What of the future? We are told that by 1960 the population of our country will be at least 17½ million, that the industrial potential of our country is tremendous, the resources unlimited.

Thus, if the resources of our country are unlimited, our resources within our Association are also. Think of the learning, the experience, the knowledge represented in C.N.A. membership! Think of the diversity of background, the variety of experience! The continuity of space and time all woven together, all there in the C.N.A., linked with the past through those who have gone before, linked with nursing afar through the I.C.N.

Perhaps nursing has come up the hard way. Certainly much has gone into the fabric of Canadian nursing. There were nursing leaders, outstanding women ,whose names we revere and whose memory we cherish. But there were others too. Little nurses! Nurses in the shadow! Hundreds of nurses who, month after month, year after year, during the busy day and through the night watches, kept the vigil. Our true prestige as a profession — and let us never forget it — comes from the skill, the courage, the devotion of our bedside nurses.

Our nurses are no longer confined to the sick room but are part of new health plans. Our horizon has broadened to include not only the care of the sick but the prevention of disease and promotion of health, nurses still caring for the sick but as well teaching health at the bedside, in the kitchen, in the factory and shop, in the school, in the community with individuals and in groups, helping people go around disease rather than through it.

What then of nursing in the future? Better still, what do you and I want for nursing in the future? This is important for we are told "Our wishes are the stars by which we set our routes." The responsibility for the nursing care of our Canadian people is ours.

Where shall we find the answer? It lies in the hearts and heads of each one of us — each member of the C.N.A.:

> The most important person in the hospital is the patient. The most important person in the community is the citizen and his family — and we add — the most important person in the C.N.A. is the member — *YOU!*

M. PEARL STIVER
*General Secretary*
*Canadian Nurses' Association*

## Cette Grande Association — La Nôtre

Sans être taxée d'égoïsme, il est naturel, il me semble, de penser aux choses qui nous touchent de près et qui nous affectent personnellement. Donc, comme secrétaire générale de l'Association des Infirmières du Canada, je vous parlerai de notre association.

Penser et dire que l'A.I.C. est notre association, c'est bien, mais combien mieux encore serait de dire: L'A.I.C. c'est nous, nous, les infirmières, sommes les personnes qui constituent les pièces de cette grande mosaïque qui est l'Association des Infirmières du Canada.

L'A.I.C. est une grande association, grande à bien des points de vue, par le nombre des membres qu'elle groupe et par les promesses que lui réserve l'avenir.

Au fait combien sommes-nous? Au moment où j'écris ces lignes, 33,050 membres — une infirmière par 447 habitants ou 0.2 pour cent de la population totale du Canada.

Faisons des comparaisons sur un autre plan. L'A.I.C. représente ⅕ des membres de l'Association des Infirmières des Etats-Unis d'Amérique, un pays qui compte une population neuf fois supérieure à celle du Canada. Les 33,050 infirmières du Canada, disons-le avec modestie, représentent la fine fleur de la gent féminine.

Maintenant, avec un peu d'imagination, essayons de disserter sur ce qui arriverait si

les 33,050 membres de l'A.I.C. étaient de "chauds" partisans. Chose certaine, le public serait bien renseigné sur les problèmes du nursing. J'aime à croire que de fait, il y aurait moins de difficulté à obtenir de l'aide pour l'éducation des infirmières. Au Canada, comme ailleurs, lorsque le public désire l'adoption d'une mesure, rien ne résiste — "Voix du peuple, voix de Dieu!"

J'aime à croire aussi que si toutes les adolescentes étaient mieux renseignées sur le merveilleux avenir que leur réserve la profession d'infirmière, l'effet sur le recrutement en serait formidable.

Et qu'arriverait-il au sein de notre association si chacune brûlait de zèle pour l'A.I.C.? Y aurait-il une seule infirmière enregistrée qui n'en serait pas membre? Tout le monde, les infirmières en premier lieu, seraient au courant des activités de l'A.I.C. Bien renseignées, elles viendraient discuter sans préjugés les programmes et les projets de l'association.

Quelles sont les promesses de l'avenir? La population du Canada en 1960 sera paraît-il de 17½ millions; le potentiel industriel de notre pays est immense et nos ressources illimitées. De même, dans notre association, les ressources sont aussi illimitées; songez à ce que l'on peut apprendre, à l'expérience que l'on peut acquérir, songez à l'ensemble des connaissances actuelles des membres de l'A.I.C., connaissances édifiées sur celles de nos prédécesseurs; songez à l'échange de ces connaissances et n'oubliez pas que par le Conseil International des Infirmières nous sommes unies aux infirmières des autres pays.

La profession d'infirmière n'en est pas arrivée où elle en est aujourd'hui sans peine. La semence jetée en terre par les pionnières, les chefs d'hier, femmes extraordinaires que nous vénérons et aimons, a germé, grâce au travail obscur mais fécond d'une multitude de petites infirmières.

N'oublions jamais que le prestige dont jouit notre profession, nous le devons à l'habilité, au courage et au dévouement des infirmières qui jour après jour, durant des mois, des années se dépensent au chevet des malades.

Aujourd'hui le service d'une infirmière embrasse non seulement les malades mais aussi les bien portants. Elle enseigne aux uns comme aux autres la prévention des maladies et le maintient de la santé. L'infirmière continue de donner des soins aux malades mais on la voit en plus à la maison, à l'usine, dans les maisons de commerce, à l'école, enseigner aux individus comme au groupe comment prévenir les maladies. Que nous réserve l'avenir?

L'avenir sera pour les infirmières ce que nous, les infirmières, le ferons. Nos désirs réalisés seront les jalons qui marqueront notre route vers le progrès.

Le public a besoin de nous et l'une des grandes responsabilités des infirmières est d'assurer à la population du Canada les soins dont elle a besoin.

Comment atteindre ce but? La réponse à cette question se trouve dans le coeur et la tête de chaque membre de l'A.I.C.

Quelle que soit l'évolution de la profession, quel que soit le genre de travail que vous accomplissiez, pour une infirmière, la personne la plus importante à l'hôpital est le malade — dans la société c'est le citoyen, le chef de famille — et dans l'A.I.C. la personne la plus importante — c'est *vous*.

M. Pearl Stiver
*Secrétaire Générale*
*L'Association des Infirmières du Canada*

## Four Famous Precepts

1. Do not argue with anyone about any matter — the evil of argument is greater than its benefit.
2. Avoid preaching unless you practise what you preach.
3. Don't offer adoration to your rulers and superiors.
4. Don't accept the gifts of princes because that is the beginning of corruption.

— Al-Ghazali, Islam's greatest philosopher

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Nobody grows old by merely living a number of years; people grow old only by deserting their ideals. Years wrinkle the skin but to give up enthusiasm wrinkles the soul. Worry, doubt, self-distrust, fear and despair — there are the long, long years that bow the head and turn the growing spirit back to dust. — *Author Unknown*

# Medical Aspects of Chemical Warfare

H. N. MacFarland, M.A., Ph.D.

THE MODERN HISTORY of the use of chemical warfare agents dates from World War I when the Germans introduced chlorine gas in an attack in 1915. Before the termination of that conflict both groups of belligerents had employed a variety of chemical agents, the most effective of which was mustard gas. In World War II both sides were prepared for the possibility of chemical attack and had stockpiled all the standard agents. Scientific teams sent into Germany by the Allies at the close of hostilities discovered that the Germans had developed a new and highly toxic series of agents which, because of their specific action on the nervous system, were named "nerve gases."* It is considered today that although any one of a number of toxic chemicals might be employed on a small scale in local sabotage attempts or in a harassing role, a generalized, full-scale chemical attack would see employment of *Nerve gases* and possibly also of *Blistering gases* of the mustard gas type. The following discussion will, therefore, be confined to a consideration of the symptomatology and treatment of casualties resulting from exposure to agents of these two groups. However, teams of specialists familiar with the treatment of casualties resulting from all known types of chemical warfare agents will be available in the major centres across the country.

## The Nerve Gases

The nerve gases are a group of organic phosphorus compounds, liquid at room temperature and essentially colorless and odorless. They exhibit a high lipoid solubility and are also soluble in water in which they are hydrolyzed; the decomposition is particularly rapid in alkaline aqueous medium. These compounds are highly volatile and the vapours are extremely toxic when inhaled or when they come in contact with mucous surfaces. The liquid nerve gases in the form of fine droplets may be inhaled. Coarser droplets are readily absorbed through the skin, particularly so through burned or wounded areas. The most striking characteristic of this group of agents is the rapidity of action, a lethal dose killing in a few minutes.

*Symptoms*: The nerve gases act with extreme rapidity and the severity of the signs and symptoms which develop depends primarily upon the amount of the agent absorbed. Following a minimal exposure to trace concentrations of nerve gas, the effects are confined to local action on the eyes and upper respiratory tract. The subject may complain of difficulty in seeing in a dim light, the result of a pupillary constriction which could last from one to three days. A mild intermittent bronchoconstriction, as indicated by a recurrent sensation of tightness in the chest, will be experienced by some individuals for a few hours. There may also be a moderate watery nasal discharge.

With a somewhat larger exposure to the agent, the onset of intermittent bronchoconstriction is very rapid and the condition is likely to persist for several days. While the difficulty in breathing is harassing, the bronchoconstriction is not sufficient to produce hypoxemia. A rhinorrhea will also be seen in most cases. The meiosis will be severe and, in addition, spasm of the ciliary muscles of the eye will be marked. The resulting difficulty of ac-

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The author, formerly with the Defence Research Board, is now on the staff of the Industrial Health Laboratory, Ottawa. This article is the last of a series reprinted, with permission, from the special issue for Civil Defence, published by the *Canadian Medical Association Journal.*

* Not to be confused with HCN, CO and other gases which also have been referred to in earlier literature as "nerve gases."

commodation is manifested by a moderate photophobia and pain when attempting to focus on near objects. The subject will probably complain of headache radiating frontally or to the occiput.

When the amount of nerve gas absorbed is approximately eight times the smallest dose capable of eliciting any detectable effects, the intensity of the symptoms may prove incapacitating in many cases. Bronchoconstriction becomes almost continuous and mild anoxemia can be detected. The individual will be confused, panicky, and will experience a sensation of suffocation.

Still larger exposures will be completely incapacitating and interference in respiration is further complicated by central and peripheral effects, a consequence of systemic absorption of the agent. Initially the bronchoconstriction is so severe that the respiratory tract may be nearly closed. Laryngeal spasm and bronchorrhea add to the great difficulty in breathing and the subject may be seized with panic in his struggle for air. In spite of vigorous muscular effort, little ventilation of the lungs will be accomplished and the resulting anoxemia may cause collapse and unconsciousness. The efforts of the respiratory muscles then decline because of (a) fatigue, (b) the effects of the anoxia of both the muscles of respiration and inhibition of the respiratory centre and (c) from a developing paralysis which follows the accumulation of acetylcholine at the myoneural junctions. The airway will now relax slightly and, since the respiratory paralysis is not complete at the dosage under consideration, the subject will likely possess enough muscular function to survive the anoxia. In the early stages, while the subject is conscious, the heart rate will be somewhat accelerated and the blood pressure elevated. Subsequently, however, when systemic effects of the absorption of nerve gas become established, there is a definite bradycardia and the blood pressure falls. As a result of the anoxia and the direct action of nerve gas on the central nervous system, muscular tremors develop, followed by fibrillary twitchings and occasional clonic-tonic convulsions. A variety of muscarinic effects of the intoxication will also be manifest under these conditions of exposure; they include profuse salivation, intestinal hypermotility resulting in nausea, vomiting, cramps and diarrhea. Urinary incontinence and premature labor may also be seen.

With lethal doses of the agent, the clinical picture is similar to that of a severe casualty but the sequence of events occurs more rapidly. The initial blocking of respiratory passages of the airway is essentially complete so that anoxia, with collapse and unconsciousness, develops quickly. Despite some relaxation which now supervenes, spontaneous respiration fails because of paralysis of the accessory muscles of respiration and central inhibition. Tonic-clonic convulsions will be followed by a generalized flaccid paralysis. The bradycardia is extreme, often resulting in a sudden and complete arrest of heart action; this may be the terminal event. Massive salivation and incontinence of urine and feces are the rule.

The signs of poisoning which develop after contamination of the skin and exposed areas differ little from those seen following inhalation of nerve gas vapor. Localized muscular twitching may be seen at the site of contamination and meiosis generally will not appear except in severely poisoned cases. However, if the eyes are contaminated with liquid nerve gas, there is an intense meiosis and ciliary spasm. It should be remembered that poisoning may occur by ingestion of contaminated food or water.

Behavioral manifestations of central effects of nerve gas may become apparent in subjects surviving the severe functional derangements. In milder cases, there may be giddiness, tension, anxiety, insomnia, and excessive dreaming. With more severe exposure, withdrawal, depression, restlessness, tremor, emotional lability, and irrational behavior may be seen.

*Treatment*: The Civil Defence organization recognizes three levels at which treatment may be undertaken: self-help, first aid, and hospital treatment. Discussion of the treatment of nerve gas casualties will be considered from the point of view of these areas.

*Self-help*: It is the responsibility of the individual to carry out personal decontamination and to fit and remove his respirator as indicated below. Since any high explosive attack may be combined with the use of chemical warfare agents, each person should fit his respirator as soon as he is aware that such an attack is in progress. It is especially important that the respirator be worn in the presence of any unidentified object emitting smoke or mist. If the individual is splashed with droplets or sees any gross liquid contamination on his person he should remove excess liquid by daubing and immediately carry out personal decontamination. All outer clothing except the respirator must be removed and discarded outdoors. The affected individual should proceed to a sheltered, uncontaminated area and remove the balance of his clothing, including the respirator. He should then wash thoroughly in running water but avoid rubbing the skin. The following materials should be applied to the contaminated areas in order of availability: bleach slurry or household equivalent such as chloride of lime solution, Javex, javel water, washing soda or baking soda. He should then sluice off with clear water, dry and dress in clean clothing. It must be emphasized that speed in carrying out the steps outlined above is most essential because of the rapidity of action of nerve gas.

*First aid*: While the procedures outlined above may be carried out by the individual if he is within a short distance of his home, he may be within range of a decontamination centre where not only the above steps but certain first aid measures may be performed. Both non-medical and medical personnel will be available in first aid stations to which the decontamination units are attached. The immediate administration of atropine intramuscularly will help relieve the central and muscarinic actions of nerve gas. The dosage employed will depend on the severity of the symptoms exhibited and will range from one injection of 2 mg. to counteract paroxysmal bronchospasm up to three injections or more in the case of casualties exhibiting severe bronchospasm and cyanosis. A thorough atropinization of the patient is desired and it must be remembered that the patient's tolerance for large doses of atropine is markedly elevated in nerve gas poisoning. The immediate use of atropine is only contraindicated when the subject has undergone a profound and prolonged anoxia. Under these circumstances, the administration of atropine may suddenly release the heart from vagal control and, in the presence of the severe anoxia, the attendant increase of the work of the cardiac muscle would almost certainly lead to ventricular fibrillation and death. Thus, in severely anoxic cases, artificial respiration should be undertaken until the lungs have been ventilated and the heart has made a partial recovery from its anoxia before atropine is administered. Holger-Nielsen, or in applicable cases the Emerson method, is recommended because procedures such as the Schafer prone pressure method, which depend upon the elastic recoil of the lungs, will be useless in patients suffering from flaccid paralysis of the respiratory musculature. A pulmotor and iron lung may be used if available.

*Hospital treatment*: Additional treatment may be indicated in the case of patients exhibiting clonic and tonic convulsions and also in those suffering intense pain and headache as a result of severe meiosis and ciliary muscle spasm.

In the case of the ocular effects, systemic atropinization may not be effective in producing relief and should be supplemented with local therapy. Mild cases will respond to the ophthalmic administration of homatropine; severer cases may require repeated instillations of atropine until good mydriasis is obtained. Convulsions may be controlled with thiopental, tridione, or ether anesthesia. If thiopental is used, overdosage must be avoided as it acts synergistically with nerve gas in depressing respiration. Tridione will depress cortical activity without depressing respiration if administered intravenously up to a maximum dosage of

5 grams. The use of these therapeutic measures is best undertaken in hospital under medical supervision. It must be remembered that convalescence may take several weeks.

### BLISTER GASES

The blister gases or vesicants include the mustard gas of World War I and the newer nitrogen mustards. These substances are oily liquids ranging in color from pale yellow to dark brown. They possess characteristic odors resembling garlic, horseradish, shoe polish or spoiling fish. The blister gases are very soluble in the usual fat solvents but are only slightly soluble in water in which they are slowly decomposed. Blister gases are classified as persistent agents since it is possible to contaminate material and terrain for long periods with the liquids which slowly and continuously emit vapors.

Because of their high lipoid solubility, vesicants are readily absorbed by the skin and they exert a local cytotoxic action leading to the development of necrotizing lesions. The vapor rapidly attacks the eyes and the warm, moist skin of the perineum, axillæ, antecubital fossæ and neck. The inhalation of mustard gas vapor may result in damage to the respiratory tract. Damage to skin and eyes will be most severe after contamination with the vesicant in the form of liquid.

*Symptoms*: After contamination of the skin by either the liquid or vapor of blister gases, there is a latent period, ranging from one hour in the event of liquid contamination to several days after mild vapor exposure. Erythema and edema are followed by the development of vesicles due to liquefaction necrosis of the underlying epidermal layers. The typical mustard blister is large and domed, thin-walled, superficial, translucent, yellowish and surrounded by erythema. The blister tends to rupture but the fluid may be resorbed over the course of several days to a week. While there is no pain at the time of contamination with mustard, an itching or mild burning may accompany the development of erythema. If blisters do develop, the area may be painful.

The eyes are affected by even very low concentrations of mustard vapor. There is a latent period of 4 to 12 hours after a mild exposure, when the first symptoms of lachrymation and a sensation of grit in the eyes become evident. The conjunctivæ and lids become red and edematous. If the exposure is more severe, the latent period is reduced and severe lesions of the eye may ensue. These include mild corneal involvement with superficial scarring and vascularization of the cornea. In very severe cases there will be necrosis of the conjunctivæ and the cornea will be deeply ulcerated with the formation of opacities. The inhalation of blister gas vapors causes damage primarily to the laryngeal and tracheobronchial mucosæ. The lesions develop slowly. The patient becomes hoarse and may become completely aphonic. A cough, particularly pronounced at night, is observed and in later stages becomes productive. Fever, dyspnea and moist râles are present and the incidence of bronchopneumonia is high. Moderate exposures produce hyperemia of the respiratory mucous membrane with necrosis of the lung epithelium. In more severe cases there is pulmonary congestion, mild patchy edema, moderately acute emphysema, and focal atelectasis. Bacterial infection of the lungs complicates the situation and suppurative bronchitis and bronchopneumonia may follow.

*Self-help*: The respirator provides complete protection for the eyes and respiratory tract and must be worn at all times when the presence of mustard vapor is suspected or reported. If the eyes become contaminated, either with droplets of blister gas or their vapor, immediate decontamination is essential. The eyes should be thoroughly irrigated immediately with copious quantities of water. Unless this is carried out within a few seconds of contamination the damage cannot be completely prevented although it may be somewhat mitigated. When available, 2% sodium bicarbonate, which is a decontaminant, followed by saturated boric acid solution or normal saline is indicated.

In the event of liquid contamination

of the skin, the free liquid should be blotted off with absorbent cloth and the latter discarded in a safe place. The contaminated area should then be treated with a bleach cream or household equivalent and then sluiced off. Lacking any of these protective preparations, the skin would be washed with soap and water after first removing gross contamination with absorbent cloth.

*First aid*: Personnel in the first aid stations are prepared to carry on with the subsequent treatment of mustard lesions. Mild conjunctivitis from blister gases may be treated by the instillation of tetracaine which will exert an analgesic action. Application of sterile petrolatum to the lid margins will prevent the eyes from adhering together. If the injuries are more severe so that edema of the lids with photophobia and blepharospasm are present and the patient is in considerable pain, apply an eye dressing with systemic sedation with morphine and the instillation of atropine sulphate solution where indicated.

Erythema of the skin from mild contamination requires little care beyond the application of a soothing lotion. If blisters have developed, a sterile petrolatum gauze dressing should be applied and, in the case of vesicles which have burst, the lesions should be treated with the same sterile technique that is employed for thermal burns.

No treatment other than rest is required for the hoarseness and sore throat which follow mild respiratory tract injury. Cough may be relieved by codeine.

*Hospital*: Hospital care is directed to limiting the invalid period and preventing complications. In the event of corneal involvement, which may be detected by staining with fluorescein, the patient should be referred to an ophthalmologist. Should the skin lesions become infected, or entry into burns or wounds suspected, specific antibacterial therapy may be instituted. If clinical signs of severe respiratory tract injuries become manifest, treatment is best given in hospital where the prophylactic administration of penicillin or sulphadiazine is recommended. The accepted practices for the treatment of bronchopneumonia will be performed there.

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# Le Rôle de la Médecine dans la Guerre Chimique

H. N. MacFarland, M.A., D.Ph.

L'HISTOIRE MODERNE de l'emploi d'agents chimiques de combat remonte à la première guerre mondiale, alors que les Allemands employèrent du chlore pour la première fois dans une attaque en 1915. Avant la fin de ce conflit, les deux groupes de belligérants avaient utilisé une foule de produits chimiques, dont le plus efficace fut le gaz moutarde. Lors de la deuxième guerre mondiale, on était prêt des deux côtés à l'éventualité d'une attaque chimique. Des équipes scientifiques envoyées en Allemagne au terme des hostilités ont découvert que les Allemands avaient mis au point une série de nouveaux agents d'une grande toxicité, lesquels, en raison de leur action spécifique sur le système nerveux, ont été appelés les "gaz névrotiques."[1]

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L'auteur, autrefois à l'office des Recherches de la Défense, est maintenant au Laboratoire d'Hygiène Industrielle, Ottawa. Ceci est le dernier d'une série d'articles du numéro spécial du *Canadian Medical Association Journal* sur la Défense Civile qui étaient publiés avec la permission de l'Association Médicale Canadienne.

[1] Ne pas confondre avec HCN, CO et d'autres gaz qui ont aussi été appelés

D'après l'opinion qui prédomine de nos jours, bien que n'importe lequel d'un certain nombre de produits chimiques pourrait être employé sur une petite échelle lors de tentatives locales de sabotage ou pour harceler, toute attaque chimique généralisée ou de grande envergure comporterait l'emploi des gaz névrotiques, et peut-être aussi celui de gaz vésicants du genre gaz moutarde. L'exposé ci-dessous se bornera par conséquent à l'étude de la symptomatologie et du traitement des victimes de l'exposition aux agents de ces deux groupes. Toutefois, il y aura, dans toutes les grandes agglomérations d'un bout à l'autre du pays, des équipes de spécialistes au courant du traitement à donner aux victimes de tous les types connus d'agents chimiques de combat.

## LES GAZ NEVROTIQUES

Le groupe des gaz névrotiques est formé de composés organiques du phosphore, liquides à la température ordinaire et de leur nature incolores et inodores. Ils sont très solubles dans les matières grasses, ainsi que dans l'eau où ils s'hydrolysent; cette dernière décomposition est particulièrement rapide dans les milieux aqueux alcalins. Ces composés sont extrêmement toxiques, même en très faibles doses, et leurs vapeurs sont aussi très toxiques lorsqu'elles sont respirées ou qu'elles viennent en contact avec des surfaces muqueuses. Les gaz névrotiques à l'état liquide peuvent être respirés sous forme de fines gouttelettes, tandis que des gouttelettes plus volumineuses s'absorbent facilement à travers la peau, et en particulier par les brûlures ou les plaies. La caractéristique la plus frappante de ce groupe d'agents, c'est la rapidité de leur action, car une dose léthale amène la mort en quelques minutes.

*Symptômes:* Les gaz névrotiques font sentir leurs effets avec une extrême rapidité et la gravité des signes et des symptômes qui en résultent dépend surtout de la quantité absorbée. A la suite d'une faible exposition à des concentrations infimes de gaz névrotique, les manifestations se bornent à une irritation locale des yeux et des voies respiratoires supérieures. Le sujet se plaint parfois de difficulté à voir sous un faible éclairage, ce qui est attribuable à un rétrécissement de la pupille des yeux qui peut persister d'un à trois jours. Certains individus ressentiront durant quelques heures une constriction bronchique modérée et intermittente, se manifestant sous forme d'une sensation récurrente d'oppression de la poitrine. Il peut aussi se produire quelque peu d'écoulement nasal aqueux.

Si l'exposition est quelque peu plus marquée, l'apparition de la constriction bronchique intermittente se produit très rapidement et cet état persistera probablement durant plusieurs jours. Bien que l'embarras respiratoire soit fatigant, la constriction bronchique ne suffit pas à provoquer d'hypoxémie. On observera aussi de la rhinorrhée dans la plupart des cas. La méiose sera prononcée et, en outre, les muscles ciliaires des yeux présenteront des spasmes marqués. La difficulté d'accommodation qui en résulte se manifeste sous forme de photophobie et de douleurs modérées, lorsque la vue tente de converger vers des objets rapprochés. Le sujet ressentira probablement un mal de tête rayonnant dans la partie frontale du crâne ou jusqu'à l'occiput.

Lorsque la quantité absorbée de gaz névrotique est d'à peu près huit fois la plus faible dose capable de provoquer des effets discernables, l'intensité des symptômes peut éventuellement frapper le sujet d'incapacité dans nombre de cas. La constriction bronchique devient presque constante, alors que l'on peut remarquer un peu d'anoxémie; le sujet sera atteint de confusion et d'affolement et il ressentira une sensation de suffocation.

Des expositions encore plus fortes frapperont les victimes de complète incapacité et l'embarras respiratoire aura en outre comme complications des effets sur les systèmes nerveux central et périphérique, conséquence de l'absorption de l'agent toxique par l'organisme. Au début, la constriction bronchique est si accusée que les voies respiratoires peuvent être presque obturées. L'aphonie spasmodique et la

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"gaz névrotiques" dans des publications antérieures.

bronchorrée ajoutent à la grande difficulté de respirer, ce qui peut frapper de panique le sujet qui se débat pour aspirer assez d'air. De vigoureux efforts musculaires ne réussiront à fournir aux poumons que peu de ventilation et l'anoxémie consécutive pourra causer la prostration et l'inconscience. Les efforts des muscles de la respiration s'affaiblissent alors (a) pour cause de fatigue, (b) en raison à la fois des effets de l'anoxie des muscles de la respiration et de l'embarras du centre respiratoire, et (c) en raison de la paralysie qui s'établit par suite de l'accumulation d'acétylcholine aux jonctions myoneurales. La tension des voies respiratoires se relâche alors et, parce que la paralysie de l'appareil respiratoire n'est pas complète à la dose envisagée, il restera probablement au sujet assez de vigueur musculaire pour survivre à l'anoxie. Dans les premières phases, alors que le sujet est conscient, le rythme cardiaque sera un peu accéléré et la tension artérielle, élevée. Plus tard, cependant, lorsque les effets de l'absorption de gaz névrotique sont bien établis, on observe une bradycardie bien marquée et la tension artérielle s'abaisse. En conséquence de l'anoxie et de l'action directe du gaz névrotique sur le système nerveux central, il se produit des tremblements musculaires, suivis de crispations fibrillaires et de temps à autre des convulsions cloniques et toniques. Dans ces conditions d'exposition, divers effets muscariniques de l'intoxication seront aussi évidents, tels une salivation abondante, une motilité intestinale exagérée qui provoque des nausées, des vomissements, des crampes et de la diarrhée. On peut aussi observer de l'incontinence d'urine et des accouchements prématurés.

Avec les doses léthales de l'agent toxique, le tableau clinique est semblable à celui des victimes gravement atteintes, mais la suite des événements se produit à un rythme plus accéléré. L'obstruction originelle des voies respiratoires est toujours totale, de sorte que l'anoxie apparaît en peu de temps, accompagnée de prostration et de perte de connaissance. Malgré une certaine détente qui survient par la suite, la respiration ne reprend pas d'elle-même en raison de la paralysie des muscles accessoires de la respiration et de celle des centres nerveux. Après des convulsions toniques et cloniques survient une paralysie flasque généralisée. La bradycardie est extrême et donne souvent lieu à un arrêt brusque et total du cœur; ce peut être là l'accident de la fin. La salivation excessive, ainsi que la micturition et les selles involontaires sont de règle.

Les signes d'empoisonnement qui se manifestent après contamination des surfaces exposées de la peau ne diffèrent que peu de ceux qu'on peut observer après l'inhalation de la vapeur de gaz névrotique. Des convulsions musculaires localisées peuvent s'observer au point de contamination mais habituellement il n'apparaîtra pas de méiose, sauf dans le cas d'intoxication grave. Cependant, si du gaz névrotique à l'état liquide atteint les yeux, il s'y produit une intense méiose et des spasmes des muscles ciliaires. Il ne faut pas oublier non plus que l'intoxication peut aussi résulter de la consommation d'eau ou d'aliments contaminés.

Les effets des gaz névrotiques sur le système nerveux central peuvent influer sur le comportement des victimes qui survivent à de graves désordres fonctionnels. Dans les cas relativement bénins, il peut se produire du vertige, de la tension, de l'angoisse, de l'insomnie et une tendance excessive à rêver. Dans les expositions les plus graves, on peut observer du retranchement, de la dépression, de la nervosité, des tremblements, de l'instabilité émotive et un comportement déraisonnable.

*Traitement:* L'organisme de la Défense Civile reconnaît trois échelons auxquels le traitement peut être institué: celui de l'aide personnelle, celui du secourisme, et celui de l'hôpital. Le traitement des victimes des gaz névrotiques sera exposé de ces divers points de vue.

*Aide personnelle:* Les masques à gaz assurent une entière protection à l'appareil respiratoire et aux yeux contre les gaz névrotiques, à la condition qu'on mette le masque avec rapidité et de façon convenable.

C'est à l'individu qu'incombe la tâche de se désinfecter lui-même et, s'il possède un masque, il ne doit pas oublier que c'est le masque qui assure le plus de protection à son appareil respiratoire et à ses yeux contre les gaz névrotiques. Autant que possible, chaque individu atteint se sauvera ou sera transporté vers un endroit non contaminé. S'il est éclaboussé de gouttelettes ou s'il constate qu'il est fortement contaminé de liquide, il épongera autant du liquide que possible, puis il s'empressera de se désinfecter. Tout en gardant le masque, il lui faut enlever tous ses vêtements extérieurs et les déposer en plein air. Il se rendra ensuite à un endroit abrité et non contaminé, où il enlèvera le reste de ses vêtements, y compris le masque. Il se lavera alors à grande eau mais sans se frotter la peau. On appliquera aux surfaces contaminées l'un des produits suivants, de préférence l'un des premiers nommés: crème de blanchiment ou équivalent domestique tel le chlorure de chaux, le Javex, l'eau de Javel, la soude du commerce ou le bicarbonate de soude.[2] On doit ensuite se rincer à l'eau claire, s'assécher et revêtir des vêtements propres. Remarquons que la célérité à exécuter les diverses opérations décrites ci-haut est des plus importante, en raison de la rapidité avec laquelle les gaz névrotiques exercent leur action.

*Secourisme:* Bien que chaque individu puisse suivre de lui-même les directives énoncées ci-dessus, s'il est assez rapproché de son domicile, il peut se trouver à distance raisonnable d'un centre de décontamination où il peut recevoir non seulement le traitement indiqué ci-haut, mais aussi certains soins, de secourisme. Les postes de secourisme auxquels sont attachées les unités de décontamination seront pourvus de personnel non-professionnel, mais aussi de personnel médical. L'administration immédiate d'atropine en injection intramusculaire aidera à atténuer l'action des gaz névrotiques sur le système nerveux central, ainsi que leurs effets muscariniques. La dose recommandée dépendra de la gravité des symptômes manifestés et variera d'une injection de 2 mg. pour arrêter les bronchospasmes paroxystiques, jusqu'à trois injections ou davantage dans le cas des victimes présentant des bronchospasmes et de la cyanose marqués. Il faut viser à atropiniser profondément le malade et se rappeler que la tolérance du malade vis-à-vis les fortes doses d'atropine est notablement accrue dans l'intoxication par les gaz névrotiques. L'injection immédiate d'atropine n'est contre-indiquée que lorsque la victime a subi une anoxie profonde et prolongée; dans ces circonstances, l'administration d'atropine peut soudainement soustraire le cœur au contrôle du vague, alors que, en présence d'une anoxie marquée, le surcroît de travail qu'elle entraîne pour le muscle cardiaque aboutirait presque inévitablement à la fibrillation ventriculaire et à la mort. Ainsi, dans les cas d'anoxie grave, il faut pratiquer la respiration artificielle jusqu'à ce que les poumons se soient bien ventilés et que le cœur se soit partiellement rétabli de l'anoxie, avant d'administrer de l'atropine. On recommande la méthode Holger-Nielsen ou, dans les cas de blessures au bras, la méthode Emerson, car les méthodes telles que celle de la pression en décubitus ventral de Schafer, dont l'efficacité repose sur l'élasticité des poumons, seront inefficaces chez les malades atteints de paralysie flasque des muscles de la respiration. Si l'on dispose d'un plumoteur ou d'un poumon mécanique, on peut y avoir recours.

*Traitement à l'hôpital:* Des soins additionnels peuvent être indiqués dans le cas des malades qui présentent des convulsions cloniques et toniques, de même que chez ceux qui ont un mal de tête et des douleurs intenses à cause d'une méiose prononcée et de spasmes des muscles ciliaires. Lorsque les yeux sont atteints, la concentration de l'atro-

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(²) La crème de blanchiment ou de chlorure de chaux se prépare en ajoutant trois parties d'eau à une partie de chlorure de chaux pour usage domestique. De même, le Javex et l'eau de Javel doivent être dilués avec trois parties d'eau. Quant à la soude du commerce et au bicarbonate de soude, il faut en dissoudre le quart d'une tasse dans une pinte d'eau.

pine dans l'organisme entier peut ne pas réussir à apporter de soulagement; il faut alors y suppléer par un traitement local. Les cas bénins céderont à l'administration d'une solution aqueuse à 1 p. 100 de bromure d'homatropine dans les yeux; les cas plus graves peuvent exiger des instillations répétées d'une solution aqueuse à 1 p. 100 d'atropine, jusqu'à ce qu'on obtienne une mydriase convenable. Les convulsions peuvent être arrêtées au moyen d'un barbiturate à effet fugace, tels le barbiturate sodique, le phénobarbital, le thiopental, ou au moyen de la tridione ou de l'anesthésie à l'éther. Si l'on a du thiopental, il faut éviter de donner une dose excessive, car il accentue par synergie l'action dépressive des gaz névrotiques sur la respiration. La tridione ralentit l'activité corticale sans affaiblir la respiration, si on l'administre en injection intraveineuse à une dose d'au plus 5 grammes. L'application de ces mesures thérapeutiques s'effectue le plus favorablement dans un hôpital, sous la surveillance d'un médecin. Ne pas oublier que, dans les cas d'intoxication grave, la convalescence peut durer plusieurs semaines.

## Gaz Vesicants

Le groupe des gaz vésicants comprend le gaz moutarde de la première guerre mondiale et les gaz moutarde à l'azote, d'invention plus récente. Ces substances sont des liquides visqueux, de couleur variant du jaune pâle au brun foncé, à odeur caractéristique ressemblant à celle de l'ail, du raifort, du poli à chaussures ou du poisson en décomposition. Elles sont très solubles dans les solvants ordinaires des matières grasses mais ne sont que peu solubles dans l'eau, dans laquelle elles se décomposent lentement. Les gaz vésicants sont classés au nombre des agents chimiques persistants, vu qu'à l'état liquide ils peuvent contaminer les objets et le sol pour de longues périodes de temps au cours desquelles il s'en dégage lentement et constamment des vapeurs.

En raison de leur grande solubilité dans les matières grasses, les gaz vésicants s'absorbent facilement par la peau, où ils exercent une action cytotoxique localisée qui aboutit à l'apparition de lésions nécrosantes. Les vapeurs causent rapidement des lésions aux yeux et à la peau chaude et moite du périnée, des aisselles, du pli du coude et du cou. L'inhalation des vapeurs de gaz moutarde peut causer des lésions aux voies respiratoires. C'est quand ces gaz sont à l'état liquide qu'ils endommagent le plus gravement la peau et les yeux.

*Symptômes:* Après contamination de la peau par les gaz vésicants à l'état de liquide ou de vapeur, il s'écoule une période latente variant d'une heure, dans le cas d'une contamination par la substance à l'état liquide, jusqu'à plusieurs jours après une faible exposition aux vapeurs. Il se produit alors de l'érythème et de l'œdème, suivis de l'apparition de vésicules ou phlyctènes causées par de la nécrose liquéfiante des couches sous-jacentes de l'épiderme. La phlyctène typique au gaz moutarde est étendue et bombée, superficielle, à paroi mince, translucide, jaunâtre et entourée d'érythème. Elle a tendance à crever, mais le liquide qu'elle contient peut se résorber au cours de quelques jours ou d'une semaine. Bien que la contamination par le gaz moutarde ne donne lieu à aucune douleur immédiate, l'apparition de l'érythème peut s'accompagner de démangeaison ou d'une faible sensation de cuisson. S'il se forme des phlyctènes, la surface atteinte peut devenir douloureuse.

Les vapeurs de gaz moutarde, même en très faibles concentrations, attaquent les yeux. Il s'écoule une période latente de quatre à douze heures après une faible exposition, alors que se manifestent les premiers symptômes de larmoiement et d'une sensation de sable dans les yeux. Les conjonctives et les paupières deviennent pourprées et œdémateuses. Si l'exposition est grave, la période latente est plus courte et il peut s'ensuivre de graves lésions aux yeux, telles une faible inflammation de la cornée, accompagnée de scarification superficielle et de vascularisation. Dans les cas très graves, on observera de la nécrose des conjonctives et de profondes ulcérations de la cornée avec formation d'opacités. L'inhalation des vapeurs d'un gaz vésicant endommage surtout les muqueuses du larynx, de la trachée et des bronches. Les lésions se forment lentement. Le malade devient enroué et il peut devenir totalement aphone. On observe une toux qui est particulièrement prononcée durant la nuit et qui, par la suite, devient productive. Il y a de la fièvre, de la dyspnée, des râles humides et la bronchopneumonie est très fréquente. Les expositions modérées rendent hyperémiques les muqueuses des voies respiratoires et donne lieu à de la nécrose de l'épithélium des poumons. Dans les cas graves, il y a de la congestion pulmonaire, un faible œdème disséminé, un degré modéré d'emphysème aigu et de l'atélectasie focale. L'infection bactérienne des poumons complique la situation et peut aboutir à la bronchite suppurée et à la bronchopneumonie.

*Aide personnelle:* Le masque à gaz assure une entière protection aux yeux et aux voies respiratoires. Il faut donc le porter constamment lorsque la présence de vapeurs de gaz moutarde est soupçonnée ou signalée. Si un gaz vésicant vient à contaminer les yeux sous forme de gouttelettes ou de vapeurs, la décontamination immédiate est d'importance primordiale. Sans perdre de temps, on rincera abondamment les yeux avec beaucoup d'eau. A moins d'effectuer ce rinçage dans les quelques secondes qui suivent la contamination, il est impossible de prévenir complètement tout dommage; cependant, celui-ci peut être passablement atténué. Si l'on a sous la main les solutions voulues, on fera bien de rincer les yeux avec une solution à 2 p. 100 de bicarbonate de soude,[3] qui agit comme décontaminant, puis avec une solution saturée d'acide borique ou du sérum physiologique.

Lorsque la peau est contaminée de liquide, on épongera le liquide superficiel avec un linge absorbant qu'on déposera ensuite dans un endroit sûr. On appliquera ensuite à la surface contaminée de la crème de blanchiment ou un équivalent d'usage domestique, puis on lavera à grande eau. A défaut de ces préparations de protection, on lavera la peau à l'eau savonneuse après avoir enlevé l'excès de contamination au moyen d'un linge absorbant.

*Secourisme:* Le personnel des postes de secourisme est en mesure de prendre charge de la suite du traitement des lésions dues au gaz moutarde. Une conjonctivite bénigne causée par les gaz vésicants peut être traitée par instillation de tétracaïne, laquelle agit comme analgésique. L'application de tétracaïne ou de vaseline officinale du commerce au bord des paupières empêchera ces dernières de se coller l'une à l'autre. Si les lésions ont une certaine gravité et qu'elles soient accompagnées d'œdème des paupières, de photophobie et de blépharospasme, et si le blessé ressent de vives douleurs, recouvrir les yeux d'un pansement, en donnant de la morphine comme calmant et instiller une solution de sulfate d'atropine, au besoin.

L'érythème cutané qui résulte d'une faible contamination exige peu de soins à part l'application d'une lotion adoucissante. S'il s'est formé des phlyctènes, les recouvrir d'un pansement de gaze stérile et, si les phlyctènes sont crevées, traiter les lésions selon la même technique aseptique qui est employée dans le cas des brûlures d'origine thermique.

*Hôpital:* Les soins hospitaliers visent à limiter la durée de l'invalidité et à prévenir les complications. Si l'on découvre une atteinte de la cornée, grâce au test de coloration à la fluorescéine, on référera le blessé à un ophtalmologiste. Dans le cas où des lésions cutanées deviendraient infectées, ou si l'on soupçonne que du gaz vésicant a contaminé des brûlures ou des plaies, on pourra instituer le traitement antibactérien exigé dans chaque cas.

L'enrouement et le mal de gorge qu'entraînent les attaques bénignes des voies respiratoires n'exigent aucun autre traitement que le repos. On peut soulager la toux au moyen de codéine. Si des signes cliniques de graves lésions aux voies respiratoires font leur apparition, c'est à l'hôpital qu'on pourra le mieux leur procurer le traitement voulu, l'administration prophylactique de

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(3) Dissoudre 2 cuillerées à table de bicarbonate de soude dans une pinte d'eau.

pénicilline ou de sulfadiazine. C'est aussi là qu'on traitera la bronchopneumonie de la façon traditionnelle. On gardera à l'esprit la possibilité d'une sensibilisation et on épiera l'apparition des réactions allergiques qui se manifestent parfois à la suite d'une intoxication par le gaz moutarde.

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# Toys, the Tools of Play

MARY GARDINER

THROUGH DEVELOPING play activities, a child learns to deal with things and to cooperate with people around him. The preschool years, coming first in the cycle of life as they do, have an important formative influence on the years that follow. Thus, the opportunity for play and the play materials with which a youngster is supplied have a profound effect on the learning process of childhood.

This was the theme of a toy demonstration presented to the public health nursing staff of the Saskatchewan Department of Public Health. The occasion was the annual Field Staff Conference of the provincial health department.

Perhaps we are too often inclined to think that education begins with the nursery school, kindergarten or Grade One but actually it begins the very day of birth. Through the processes of maturation as the child comes to grips with his environment — largely through play — toys are the tools that aid in physical, mental, and emotional development.

Wisely selected play materials stimulate activity and initiative in a child. They give him an opportunity to express himself and to exercise his newly acquired abilities in each of the successive stages through which he goes as part of his normal development. Toys, thus, not only keep the child amused and busy but they keep him developing.

Parents and other adults selecting toys for children should, of course, always consider the age of the child for whom they are intended. While chronological age can serve as a general guide, the level of development and interests of the child should always be taken into consideration. He should always have some that are somewhat beyond him so he will be stimulated towards the next stage of development.

A child should have a variety of toys — some to aid his muscular development, some to encourage his imagination, and some to promote imitative play. Various types are necessary because his attention span is short. On the other hand, too many will tend to distract him. During his first years particularly, a child usually wants to play with a few favorite toys.

By the age of three, children begin to play with each other and toys providing for social play such as toy telephones, dishes, wagons, become important.

A child should have a place to keep his toys and be encouraged to put them away — a practice that will help to develop his sense of responsibility and eliminate dangerous tripping hazards in the home.

Parents should give special thought to safety in the construction of toys to see that there are no small parts that can be pulled off and swallowed, dolls' eyes that may be chewed out, or sharp edges that could cause injury. Specially recommended toy paints containing a minimum of lead should always be used if homemade materials are utilized or if cribs or children's furniture are being repainted.

Because of the continuity characteristic of play behavior throughout childhood years, well made durable dolls,

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*Photo by Lynn Mann, Health Education Division*

Here is a portion of the toy display used in connection with the toy demonstration presented to the public health nurses of the Saskatchewan Department of Public Health at the Field Staff Conference.

construction sets, building blocks and doll corner materials are preferred. What differs from age to age is how the child uses the toy. Good carpentry tools and blunted scissors are also a worthwhile investment.

While there is much individual variation among children, research studies show that there is an orderly sequence of development. Therefore, age can serve as a general guide in toy selection.

Toys for infants — under 12 months —should be brightly colored and of a simple type such as balls, rattles, plastic rings and bracelets, spools, soft washable animals, bath toys and cubes.

When a child begins to move about under his own power, attention should be paid to toys that will help develop his physical strength and motor skills. Large, simple, durable toys that can be pulled apart and put together again, push-and-pull toys, large light blocks, small wagons and doll carriages, bingo beds and unbreakable dishes are some of the toys suitable for this age.

By the age of three, dramatization and imitation usually begin to enter play activities. While muscular development through active physical play is still a major consideration, doll corner equipment, junior-size housekeeping toys, simple boats and trains help to encourage dramatic and imitative play. Large crayons, clay and finger paints will meet the need for creative activities.

At the ages of five and six, a child begins to gear his play activities to a definite purpose — he will build a structure from blocks, name it and play with it. There are many toys and raw materials to supplement the make-believe that dominates play activities of this period, such as garden tools, playhouses, housekeeping materials, trucks, trains and telephones. For active play there are scooters, skates, tricycles, wagons and skipping ropes. Tools, more elaborate block sets, clay, blunt scissors and colored paper will encourage self-expression and help develop finer hand muscles as well.

Fortunately for parents, many of the toys that a child needs can be made at home or improvised from household articles. Colored plastic dishes, spools and corks, homemade blocks, firm colored cloth, old magazines to leaf through and cut up, stuffed dolls and animals, clothespins, and home-constructed doll houses are only a few examples.

When a child is furnished with suitable raw materials and encouraged to use his imagination, ingenuity and initiative in his play, he is learning and his toys are his tools.

# Public Relations and the Nurse

P. S. DEIS

### WHAT ARE PUBLIC RELATIONS?

THE PHRASE is difficult to define but in the final analysis it is what others think about you, the feelings they have towards the profession as a whole and, therefore, by necessary implication, towards the nurse as an individual. The public, whose opinions we are trying to influence, is becoming increasingly a mass mind influenced by slogans, not by reasons; perhaps because the use of reason is becoming old-fashioned. Where formerly self-education was a normal part of the process of growing older, now, except in the learned professions, it is laughed at.

Cardinal Newman has said: "Any self-education in any shape, in the most restricted sense, is preferable to a system of teaching which, professing so much, really does so little for the mind."

It is from this text that Dr. Hilda Neatby of the University of Saskatchewan has taken the title for her book, "So Little for the Mind." She has done a thorough job of exposing our present educational system to the clear light of day. One passage reads thus:

> The bored "graduates" of elementary and high schools often are ignorant of things that they might be expected to know and they do not care to learn. They lack an object in life; they are unaware of the joy of achievement. They cannot read, write or think. They can often type but too often they cannot construct a grammatical sentence. They can emit platitudes but they can neither explain nor defend them. They are as incapable of logic as they are ignorant of its name. Yet they are not stupid, or ill-intentioned or incurably indifferent to what they have never learned to call their duty. They are only ignorant, lazy, and unaware of the exacting demands of a society from the realities of which they have been carefully insulated.

It is this type of individual that we are concerned about when we speak of public relations. Not many people, and that includes nurses, are perfectly logical in their thinking. Thought processes vary in different individuals and not many arrive at conclusions by the use of the syllogism. Far more people arrive at their conclusions by a perversion of logic called induction—that is, arguing from the particular to the general. It might go something like this: "I know a lady who has some bad habits. This lady is a nurse. Therefore all nurses have bad habits." One nurse may make a bad impression. How many are there who will say, "Those nurses are all the same."

There are many outstanding examples of poor public relations. Remember the conditions through which we passed in the "dirty thirties"? During that phase banks were among the most unpopular institutions in the country. They were not lending money and everybody was against the banks. Not only that, they tried to collect from borrowers the money that had been lent to them. The banks simply went about their job the best way they knew how. In spite of the fact that in the far richer country to the south of us thousands of banks went under, in Canada we didn't have a single bank failure. Our banks operated on the premise that it wasn't their money they were lending; that the money they used belonged to the depositors and the banks were the custodians or trustees.

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The author is a barrister, solicitor and notary public in Regina, Sask.

In many cases people who objected to the fact that banks weren't lending money would not have lent their own money to the vast majority of people who were refused credit by the banks. However, while public opinion against the banks as institutions became a rising tide the banks did nothing themselves to stem that tide. They did not inform the public as to what their functions were. Then banks began to look to their public relations and there came a change. Now you hear no condemnation of the banks either as institutions or as individual concerns. They have improved to a very large extent the opinions of the public regarding them — in other words they have good public relations.

Those of you who have had dealings with plumbers know that they don't have good public relations. There are countless stories about plumbers forgetting their tools and then charging for the time it takes to go back to the shop to pick them up and return to the job. There are just as many stories about plumbers promising to be on the job on Tuesday morning and then not showing up for two weeks, while the poor housewife is frantically trying to stop the drip.

I think I see a falling barometer so far as the medical profession is concerned, due not so much to the profession as such, but to the lack of consideration on the part of many individual practitioners. How long do you think the public is going to stand for having received an appointment for two o'clock on Wednesday afternoon, being in the doctor's office shortly before two, and then having to wait until five or six o'clock to see the doctor? During this interval the person will have found out in the waiting room that at least ten others also had appointments for two o'clock. Sitting room is at a premium throughout the entire period.

Such conditions are bound to create resentment. So long as the existing shortage of doctors continues doctors will get away with that kind of thing. But even now there is a growing demand for some type of state or socialized medicine. People are looking for a way out of the strait jacket in which the medical profession appears to have them.

You may have taken your fur coat to the furrier in the spring to have some remodeling done. He told you that you would have it by the end of September; in fact, he advertised over the air that during the summer months was the time to get this work done. The middle of October came along and you hadn't heard about your coat so you telephoned and were told that you should have it in a couple of weeks. Then on the first of November you called again: you were told it was not quite ready. On the 10th of November you went down to the furrier's only to find that your coat hadn't even been started!

All these are examples of poor public relations. Make no mistake about it! These irritations reflect upon not only the individuals concerned but upon the entire trade, industry or profession involved. Public opinion is formed by a composite of the impressions left in the minds of those we come in contact with but is very apt to be tempered or influenced by extraneous factors. It is strange but nevertheless true that people are more ready to believe evil of others than they are to believe good. Lenin was the first world figure not only categorically to state this fact but to make use of it on a large scale. Stalin profited by the Lenin experience and he was the first to attempt it on a colossal scale. It was he who evolved the technique of the big lie. He said that if you tell a lie big enough and often enough people will believe it. Hitler and his propaganda minister Goebbels took a leaf right out of the book of Stalin and added some refinements to the technique. The big lies were told about themselves, to reflect to their own credit and intended to enhance their own stature and the standing of their nation among the community of nations. The technique was just as effective when the lies were told so as to inflict discredit upon other persons, other groups or other organizations.

I introduce these thoughts to indicate that the impression left in the minds of those with whom you come in contact may be distorted by isolated aberrations practised by a few. The result is to shower discredit not only upon that individual but also upon the group or profession to which that individual belongs — like the thoughtless doctor, the overcharging or forgetful plumber, the careless furrier, or the malpractising nurse.

What should be the relation of the nurse to the doctor? That relationship is primarily and fundamentally professional. First and foremost the nurse should be the effective and efficient agent of the doctor to carry out his orders. The nurse has a duty to herself, her patient, and her profession to keep up with new professional ideas, new techniques and new methods of applying old techniques. She will, if she is on her toes, acquire and deserve the respect of the medical profession. Equally important is the greater respect she will earn from the patients placed under her care and others with whom she comes in contact. She will also enhance in the minds of all these people the regard in which the nursing profession as a whole is held.

A sense of humor is an unfailing help for a successful nurse. It is possible to combine a serious, responsible sense of purpose in life with a jubilant sense of humor. Humor is a joyful quality that springs from the heart. It is more friendly than fun, more kindly than wit, and infinitely more satisfying than flippancy. It does not see anything funny in crude practical jokes or in injuring others or in destroying property because it does not thrive on cruelty or vandalism. Humor enables one to be serious without being pompous; it preserves one's sense of proportion; it enhances one's courage; and it engenders sympathy and affection among those who smile together, or laugh together, or sing together.

The same cheerfulness should, of course, be present when the nurse is dealing with the relatives and friends of her patient. I do not suggest the backslapping kind of cheerfulness but rather a cheerfulness born of feelings of consideration and kindness. We all think our own troubles are the greatest there are. When we ourselves are in trouble we seldom have time to think of the troubles of others; in fact we don't want to be bothered by them. The nurse really has no time for troubles of her own! If she is possessed of such an essential feeling of consideration for others she will forget her own problems in trying to alleviate the troubles of others. By doing that she will help them to bear up and accept their lot in life with as much cheerfulness as she herself can muster.

My recommendation for good public relations on the part of the nursing profession is that each individual nurse take it upon herself to cultivate those qualities that will make her a good nurse, loved by her fellows, respected by her patients and the friends of her patients, and admired by the medical profession and her employers. If everyone sweeps in front of her own house the whole city will be clean!

## Things Money Can't Buy

Money can't buy real friendship — friendship must be earned.

Money can't buy a clear conscience — square dealing is the price tag.

Money can't buy the glow of good health — right living is the secret.

Money can't buy happiness — happiness is a mental attitude and one may be as happy in a cottage as in a mansion.

Money can't buy sunsets, songs of wild birds, and the music of the wind in the trees —these are as free as the air we breathe.

Money can't buy inward peace — peace is the result of a constructive philosophy of life.

Money can't buy character — character is what we are when we are alone with ourselves in the dark.

— Courtesy of *Mutual Moments*

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Man must teach himself that the basest of all things is to be afraid; and teaching himself that, forget it forever, leaving no room in his workshop for anything but . . . the old universal truths — love, and honor and pity and pride and compassion and sacrifice.

— William Faulkner

# The Wild West

Hugh Dempsey

Only 200 years ago, Alberta was a vast wilderness in which the white man was a stranger. It was the undisputed empire of the Crees and Blackfoot who lived happily and simply off the teeming wildlife of the land. Countless herds of buffalo provided an almost unlimited supply of meat and other birds and animals were plentiful in the northern bushlands.

That is how the country looked to Anthony Henday, a young Englishman who pierced the unknown land in 1754. Sent out to make friends with the Indian tribes, Henday is believed to have come as far west as the Didsbury district and was the first white man to gaze upon the Alberta plains. It was in this country that Henday met the Blackfoot and unsuccessfully tried to induce them to accompany him to trade at Hudson Bay.

Following this historic journey, no attempt was made to enter the west for several years. Then, as the trade between the Hudson's Bay Company and "freeman" became more spirited, the rugged explorers began to push into the unknown land.

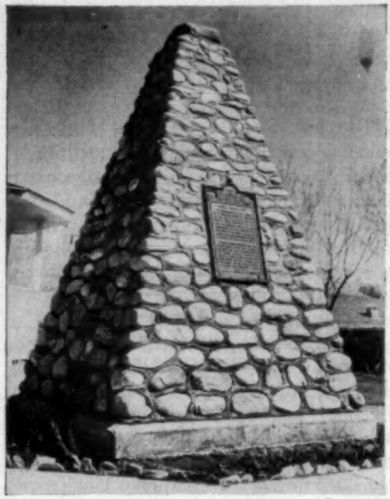
Peter Pond, representing a number of free traders, was the first man to travel a westward flowing river in that part of Canada when he portaged to the Clearwater River and followed it to the Athabasca in 1778. When the North West Company was formed, many other traders followed the same route and the areas around the Peace and Athabasca rivers became important sources of furs.

Rivalry and bitterness soon arose between the two leading fur companies as the North West Company led the trade into the west. Posts often were built side by side, both for mutual protection against the Indians and to give greater competition in trade. Among these in Alberta were Fort George and Buckingham House built in 1780; Forts Edmonton and Augustus, 1794; Acton House and Rocky Mountain House, 1799; Island Houses, 1801; and Fort Vermilion, 1808. The rivalry continued unabated until 1821, when the two companies amalgamated under the name of Hudson's Bay Company. From that date until the arrival of the North West Mounted Police in the west in 1874, the main history of Alberta belongs to the great trading company.

The energies of the traders were not devoted exclusively to the fur trade. Exploration was carried on continually by the rugged men of the wilderness who dreamed of opening new lands and extending their profitable activities into the unknown. Alexander Mackenzie, using Fort Chipewyan as his base, discovered the Mackenzie River and followed it to the Arctic Ocean in 1789. Then, in 1793, he left Fort Fork on the Peace River and became the first white man to cross North America by land. Other men, like David Thompson, Philip Turner, Boyer and Harmon, contributed a wealth of knowledge about the new land.

Following the transfer of Rupert's Land to Canada by the Hudson's Bay Company in 1868, developments in the west underwent a rapid change. The prairies were under practically no authority and American traders saw an excellent opportunity to widen their illicit activities of trading whiskey to the Blackfoot Indians. Trading posts

*These chimneys are all that remain of the old fort, located a few miles west of the town of Rocky Mountain House, Alberta.*



*Cairn at Fort Macleod commemorating the establishment of the first Mounted Police post on the Western Plains.*

were set up as far north as Calgary and for several years they took most of the trade that had formerly gone to Rocky Mountain House and Fort Edmonton.

The first, and most famous, of the posts was Fort Hamilton or Whoop-Up, which was built near the present city of Lethbridge in 1869. Other equally colorful sites were Standoff, Slideout and Kipp. All were nicknamed "whiskey forts" because of the claim that they sold only firewater to the Blackfoot tribes. Their presence on Canadian soil was a disturbing factor to British companies and officials who visited the west and an undertone of resentment was voiced by many of the early pioneers.

The protests by Canadian fur traders and missionaries against the American traders were answered in 1874 when the Canadian Government formed the North West Mounted Police. Under the direction of Col. French, 300 men proceeded to Dufferin, Manitoba, and set out for the historic trek across the great unknown plains. One division was sent to the Oldman River, another to Fort Edmonton, and the third to Swan River, Manitoba. Arriving at the Oldman River in the late autumn, the Mounted Police under Col. J. F. Macleod built a post and named it Fort Macleod. Before a year had passed, the Canadian prairies were virtually free of illicit whiskey trading.

With the establishment of law and order in southern Alberta, the first pioneers of the ranching industry began to arrive. The treaty with the Crees was signed at Fort Pitt in 1876. The Blackfoot Treaty was endorsed a year later in the south. These pacts rang the death knell of the shaggy buffalo as cattle rapidly began to replace them. Early ranchers obtained contracts to supply beef to the Indians and to the Mounted Police detachments. Within a few years, the "Wild West" had disappeared and a new era of development began.

In 1885, the rumblings of discontent that had shaken the west for several years exploded into the uprising of the half-breeds in Saskatchewan under Louis Riel and the massacre of the inhabitants of Frog Lake, Alberta, by Crees. Forts were set up in Alberta at Red Deer, Ponoka and Wetaskiwin, while existing posts at Edmonton, Calgary and Fort Macleod were reinforced in case the insurgents should move westward into Alberta. The Alberta field force was organized under T. Bland Strange and marched from Calgary to Edmonton, thence down the Saskatchewan, to subdue the Crees under Big Bear. Although short-lived,

*Cairn on the Fort Macleod-Cardston highway. Chief Red Crow of the Blood Indians signed treaty in 1877 for his branch of the Blackfoot Confederacy.*

the rebellion left an indelible mark on the history of the west.

It was not until 1905 that Alberta was organized into a separate autonomous province. It was named after Queen Victoria's daughter, Louise Caroline Alberta, wife of the Marquis of Lorne who was Governor-General of Canada at that time. From 1900 until 1910 the growth of the west was spectacular, with Alberta's population jumping from 73,000 to 375,000. Dozens of new towns sprang up and agriculture became increasingly important to the province.

Natural resources were taken over by Alberta from the Dominion Government in 1930. This gave the province complete control over 120,000 square miles of forests, more than three trillion tons of coal, more than 50 million acres of farmland, and vast reserves of oil, natural gas, tarsands, gypsum, salt and other precious resources. Since that time, oil has been discovered in many parts of Alberta, including Leduc, Redwater, Turner Valley, and Lloydminster. Natural gas has become important and is used extensively in homes and industry.

Alberta still has its rolling prairies and rich forests but the gradual change from trapping to agriculture has brought the colorful history of the province to its richest and most important era — the industrial era. Agriculture and industry now are working hand in hand, to make Alberta one of the most promising areas on the continent.

# Is it the Answer?

Esther Paulson

It is not a simple matter to present one's impressions of the Structure Study Report as a guide to the membership in studying it because knowledge ranges from casual interest to careful reading of the Report and conscientious attempts to understand the implications involved.

Many nurses were consulted here as to the extent of their knowledge about the Report and the type of information which, in their opinion, would be most helpful in studying it further. The replies were unanimous:

> The recommendations are available for the reading — but we are not sufficiently conversant with nursing affairs or the organizational problems to draw our own conclusions as to whether the recommendations of the Structure Study are necessarily what is best for the nursing profession as a whole. Tell us about the implications involved in the main recommendations.

This paper, therefore, is intended for those members who may not be too familiar with the recommendations in relation to the prevailing situation or the effect of the proposed changes in our national and provincial organizations. The article "Operation C.N.A.," published in the October, 1953, issue of *The Canadian Nurse,* explains the basic organizational changes very clearly but the significance of the changes is more apparent if studied in relation to the prevailing set-up. The chart in this paper was prepared to assist in making a comparative study as that part must be understood before considering the implications involved.

A logical starting point, therefore, would seem to be the recommendation dealing with the size and composition of the Executive Committee as this point is conceded to be the most controversial in the entire report.

The prevailing organization provides for two members from each provincial association on the national Executive. They are the provincial president and one other — usually the executive secretary. The proposed

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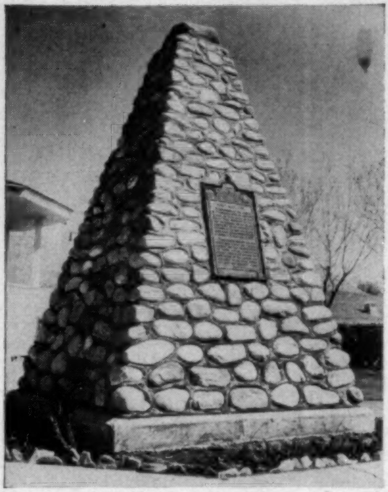
Miss Paulson, who is superintendent of nurses, Pearson Tuberculosis Hospital, Vancouver, B.C., was a member of the C.N.A. Structure Study Committee.



*Cairn at Fort Macleod commemorating the establishment of the first Mounted Police post on the Western Plains.*

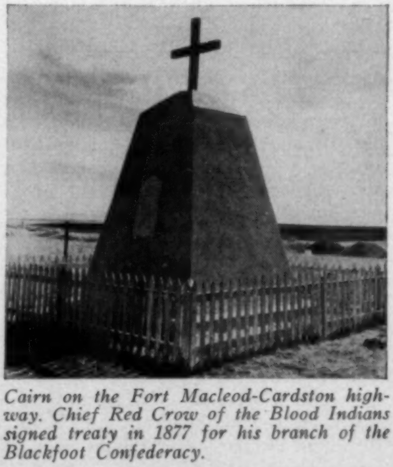
were set up as far north as Calgary and for several years they took most of the trade that had formerly gone to Rocky Mountain House and Fort Edmonton.

The first, and most famous, of the posts was Fort Hamilton or Whoop-Up, which was built near the present city of Lethbridge in 1869. Other equally colorful sites were Standoff, Slideout and Kipp. All were nicknamed "whiskey forts" because of the claim that they sold only firewater to the Blackfoot tribes. Their presence on Canadian soil was a disturbing factor to British companies and officials who visited the west and an undertone of resentment was voiced by many of the early pioneers.

The protests by Canadian fur traders and missionaries against the American traders were answered in 1874 when the Canadian Government formed the North West Mounted Police. Under the direction of Col. French, 300 men proceeded to Dufferin, Manitoba, and set out for the historic trek across the great unknown plains. One division was sent to the Oldman River, another to Fort Edmonton, and the third to Swan River, Manitoba. Arriving at the Oldman River in the late autumn, the Mounted Police under Col. J. F. Macleod built a post and named it Fort Macleod. Before a year had passed, the Canadian prairies were virtually free of illicit whiskey trading.

With the establishment of law and order in southern Alberta, the first pioneers of the ranching industry began to arrive. The treaty with the Crees was signed at Fort Pitt in 1876. The Blackfoot Treaty was endorsed a year later in the south. These pacts rang the death knell of the shaggy buffalo as cattle rapidly began to replace them. Early ranchers obtained contracts to supply beef to the Indians and to the Mounted Police detachments. Within a few years, the "Wild West" had disappeared and a new era of development began.

In 1885, the rumblings of discontent that had shaken the west for several years exploded into the uprising of the half-breeds in Saskatchewan under Louis Riel and the massacre of the inhabitants of Frog Lake, Alberta, by Crees. Forts were set up in Alberta at Red Deer, Ponoka and Wetaskiwin, while existing posts at Edmonton, Calgary and Fort Macleod were reinforced in case the insurgents should move westward into Alberta. The Alberta field force was organized under T. Bland Strange and marched from Calgary to Edmonton, thence down the Saskatchewan, to subdue the Crees under Big Bear. Although short-lived,



*Cairn on the Fort Macleod-Cardston highway. Chief Red Crow of the Blood Indians signed treaty in 1877 for his branch of the Blackfoot Confederacy.*

the rebellion left an indelible mark on the history of the west.

It was not until 1905 that Alberta was organized into a separate autonomous province. It was named after Queen Victoria's daughter, Louise Caroline Alberta, wife of the Marquis of Lorne who was Governor-General of Canada at that time. From 1900 until 1910 the growth of the west was spectacular, with Alberta's population jumping from 73,000 to 375,000. Dozens of new towns sprang up and agriculture became increasingly important to the province.

Natural resources were taken over by Alberta from the Dominion Government in 1930. This gave the province complete control over 120,000 square miles of forests, more than three trillion tons of coal, more than 50 million acres of farmland, and vast reserves of oil, natural gas, tarsands, gypsum, salt and other precious resources. Since that time, oil has been discovered in many parts of Alberta, including Leduc, Redwater, Turner Valley, and Lloydminster. Natural gas has become important and is used extensively in homes and industry.

Alberta still has its rolling prairies and rich forests but the gradual change from trapping to agriculture has brought the colorful history of the province to its richest and most important era — the industrial era. Agriculture and industry now are working hand in hand, to make Alberta one of the most promising areas on the continent.

# Is it the Answer?

ESTHER PAULSON

IT IS NOT A SIMPLE MATTER to present one's impressions of the Structure Study Report as a guide to the membership in studying it because knowledge ranges from casual interest to careful reading of the Report and conscientious attempts to understand the implications involved.

Many nurses were consulted here as to the extent of their knowledge about the Report and the type of information which, in their opinion, would be most helpful in studying it further. The replies were unanimous:

> The recommendations are available for the reading — but we are not sufficiently conversant with nursing affairs or the organizational problems to draw our own conclusions as to whether the recommendations of the Structure Study are necessarily what is best for the nursing profession as a whole. Tell us about the implications involved in the main recommendations.

This paper, therefore, is intended for those members who may not be too familiar with the recommendations in relation to the prevailing situation or the effect of the proposed changes in our national and provincial organizations. The article "Operation C.N.A.," published in the October, 1953, issue of *The Canadian Nurse,* explains the basic organizational changes very clearly but the significance of the changes is more apparent if studied in relation to the prevailing set-up. The chart in this paper was prepared to assist in making a comparative study as that part must be understood before considering the implications involved.

A logical starting point, therefore, would seem to be the recommendation dealing with the size and composition of the Executive Committee as this point is conceded to be the most controversial in the entire report.

The prevailing organization provides for two members from each provincial association on the national Executive. They are the provincial president and one other — usually the executive secretary. The proposed

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Miss Paulson, who is superintendent of nurses, Pearson Tuberculosis Hospital, Vancouver, B.C., was a member of the C.N.A. Structure Study Committee.

### CHART SHOWING PRESENT AND PROPOSED COMPOSITION OF THE EXECUTIVE AND SUB-EXECUTIVE COMMITTEES AND STANDING COMMITTEES OF THE CANADIAN NURSES' ASSOCIATION

| *Present* | *No.* | *Proposed* | *No.* |
|---|---|---|---|
| President | 1 | No change | 1 |
| 1st<br>2nd Vice-Presidents<br>3rd | 3 | No change | 3 |
| Nominated by Provincial Associations, elected each biennium | | (same) | |
| Past President | 1 | No change | 1 |
| Representatives from the provinces<br>Two from each province:<br>(a) the Provincial President<br>(b) one other member named by Prov. Exec., usually Prov. Exec. Secretary | 18 | Members of the Ass'n. from the prov. To be the Prov. President unless already a national officer, then substitute member chosen by Prov. Ass'n. from among voting members of Prov. Exec.<br>[See p. 17 (a) (iii) Structure Study] | 9 |
| Representatives from Nursing Sisterhoods nominated by Prov. Ass'ns. elected each biennium | 5 | Members of the Ass'n. from the Sisterhoods, nominated by Prov. Ass'ns. elected each biennium<br>[See p. 34 & p. 17 (a) (iv)] | 3 |
| Chairmen, National Committees<br>(1) Institutional Nursing<br>(2) Private Duty Nursing<br>(3) Public Health Nursing<br>— elected each biennium | 3 | Chairmen, Six Standing Committees<br>(1) Nursing Service<br>(2) Nursing Education<br>(3) Personnel Problems<br>(4) Communications<br>(5) Finance<br>(6) Constitution & By-Laws | |
| (4) Educational Policy<br>(5) Legislation<br>— appointed by Exec. Com. | 2 | Committee Chairman appointed by Sub.-Exec. from members on the Exec. Com., as follows:<br>2nd Vice-President<br>3rd Vice-President<br>1 member from Sisterhoods—p. 49<br>3 members from provinces — p. 46 & 47 | |
| Total membership Executive Committee | 33 | Total membership Executive Committee | 17 |

C.N.A. pays expenses for:

| | |
|---|---|
| 5 Officers | 5 Officers |
| 3 Chairmen Standing Committees (1, 2, 3 above) | 9 Members of Association — provinces |
| 2 Chairmen Special Committees (4, 5 above) | 3 Members of Association — Sisterhoods |
| 9 Rep. Provinces | |
| 5 Rep. Sisterhoods | |
| 24 | 17 — This total would be increased if the selection of Committee Chairmen is not limited to members of the Executive Committee. |

change reduces the Executive membership from 33 to 17 by limiting the provinces to one member each — the provincial president. She attends the national Executive meetings, not as a *representative* of a provincial association but as a *member* of the executive from a province. In this capacity the Report recommends that:

1. She is not committed to provincial thinking in debate or in voting.
2. She would not necessarily vote as directed by the provincial association.

The same philosophy applies to voting delegates from the provinces at biennial meetings.

Two points of view may be derived from this recommendation. The intent of the Report that nurses should be aware of provincial thought but free to act as a result of argument and mature thought is a logical and desirable objective. On the other hand, the C.N.A. is a federation of nine provincial associations and it seems inconsistent to eliminate the provincial aspect in dealing with nursing affairs and policy at the national level. Members go to the national Executive or biennial meetings with knowledge of nursing affairs gained from participation and group thinking at the provincial level. National representatives in government are influenced by their knowledge of conditions and needs in the respective provinces and districts. In a country as diversified as Canada it would seem that policies of national import, whether in governmental or professional affairs, should be arrived at as a result of cross-country thinking and participation in order that eventual compromise and progress may be national in scope.

It would seem to make little difference whether the members are designated as members or representatives from the provinces on the national Executive. The responsibility for speaking and voting as individuals presupposes that the provincial presidents on the Executive Committee and voting delegates to the biennial convention are *adequately* informed on the various issues affecting the profession, the membership, and the public. Provincial presidents usually carry full-time, heavy nursing positions in addition to their participation in professional affairs. Consequently, they cannot possibly be as well informed on organizational matters as the executive secretary who frequently must act as spokesman, particularly when the president is new in office.

In so far as the voting delegates at biennial conventions are concerned, it is difficult to understand how the many voting delegates, scattered throughout the nine provinces, can be prepared sufficiently to be able to deal with the pros and cons of the proposed policies in order to vote intelligently. It is suggested, on page 42 of the Report, that this is the job of both the voting and non-voting members of the Executive Committee, to be handled through field trips and meetings. It is emphasized that provincial associations shall have no control over the decisions of the voting delegates. From personal experience I would not wish to assume responsibility for voting as an individual. The practice of referring matters to the provinces ensures broader consideration and decisions on national policies that have some hope of implementation on a national scale. The time saved in eliminating this procedure does not appear to be a justifiable reason for change.

It is true that the size of the Executive Committee involves considerable travelling expense to bring members to the meetings. However, it does seem unwise to reduce the national Executive at a time when our membership is increasing and professional responsibilities are expanding at all levels. The nursing profession, the membership, and the public might be served more effectively by maintaining the Executive at the present number as well as enlarging the staff at National Office. Whether provincial executive secretaries continue to be the second member from each province is not a major point. It is important, however, that the attendance of this group at Executive meetings be safeguarded. They are the full-time representatives of the nursing profession throughout the country. As such they must be well informed and able to give interpretation and leadership if progress is to be made in the component parts of the C.N.A. — the provinces.

The recommendation dealing with the Standing Committees, if adopted, will correct the prevailing, top-heavy structure of standing and special committees. The change involves the dissolution of the three committees on institutional nursing, private nursing, and public health nursing. The six main committees as proposed would cover many nursing matters, affecting all three specialities, which are now outside the sphere of the three existing committees. Selecting the six chairmen from among the 14 members of the Executive Committee might prove to be a limiting factor in obtaining the best qualified people to head up the respective committees. An identical committee pattern in the provinces, with the provincial chairmen as members of the corresponding national committees, would facilitate action and progress along uniform lines. This part of the Report is dealt with on pages 46, 47 and 48. The proposed plan is clear-cut and desirable if recognized channels of communication are followed.

It is a matter of concern, therefore, to read in "Operation C.N.A." that the Structure Study recommends by-passing the provincial associations entirely, by making it possible for individuals or groups of nurses, even chapters and districts, to bring matters directly to the national Executive through the national committee chairmen. A comparable situation in an institution or agency would mean that staff nurses could take nursing problems directly to the administrator without discussion or a referral to the nursing director or her associates. It would seem that in not following suitable channels of communication, frustration and confusion would be the lot of the provincial associations. This has happened in our present set-up whenever provincial chairmen or other members have gone directly to national sources instead of following through the proper channels. By-passing the provincial associations will surely lead to serious separation and unbridged gaps between the provincial and national sections of our nursing organization.

The voting procedure, as proposed in the Report, seems to present some inconsistencies. Voting delegates vote individually, without the direction or influence of the provincial association, on matters of policy but may vote as a block for elected officers as directed by the provincial association. The explanation given for this difference in voting is that election of officers concerns the provinces more directly than voting for policy and other matters. If the C.N.A. is a federation of constituent parts — the provincial associations — then policy should be of vital concern to the provinces. True, the provincial associations are free to reject or accept but national policies in theory only are meaningless without the application that can only come at the provincial level. Therein lies the real need for active participation of the provincial associations in nursing affairs at the national level.

The examination of the structure of our national organization was a necessary development and the Report has revealed some weaknesses and made suggestions for some much needed changes. However, sweeping acceptance of all the recommendations would not seem to be advisable. It is easier to avoid mistakes than to correct errors, especially if those errors should result in divided loyalty and interest in our professional affairs. The Structure Study has done part of the job but it would appear that the examination has not gone deeply enough into all of the ramifications. If the future is to learn from the past then we in this generation have an obligation to make studies of existing conditions as informative as possible. For this reason it is regrettable that the Structure Study is not a scientific one, as asked for in the directives. The director herself has stated on page 11 of the Report that "it is simply a drawing together of ideas and impressions gained from chatting with many nurses and others."

Provincially and nationally our professional organizations are growing in stature and viewpoints are broadening as membership on provincial executive bodies becomes more widely representative. It would seem that a national spirit and approach depends not on separating or severing the national-provincial links, but on welding them more strongly into a unified whole. National policies formulated through joint participation and shared responsibility are more certain of being translated into actual practice in the provinces, thus creating a national standard for the nursing profession in this country.

## I.C.N. Activities

*International Nurses' Screening Board:* The responsibility of the I.C.N. in connection with displaced nurses continues to be an important part of our work and the Register of these nurses is carefully maintained and kept up to date.

Arising out of this particular activity, an increasing number of inquiries reach our Headquarters concerning the professional qualifications of nurses seeking temporary or permanent employment outside their own countries, and also concerning the standard of the schools where they received their basic education. Assistance is given whenever it is possible, and seems appropriate, in obtaining the necessary details. The collaboration of national nurses' associations is always sought in establishing the credentials of their members.

To some of our readers, statistics may be of interest. During the month of October, 1953, 242 letters have been written in connection with this work, which has involved correspondence with 14 countries (in the case of the U.S.A., with nine states, and in the case of Canada, with five provinces).

*Florence Nightingale International Foundation*: The director was invited by the Association of Nurses in the Northern European countries to participate in a meeting called by this association with its representatives and the directors of the post-basic schools in Denmark, Finland, Norway, and Sweden. The meeting, which took place in Stockholm, had as its object the discussion of a survey of these schools, recently undertaken by the association. The important items for this group to consider were:

1. The correctness of information gathered by the study makers during their visits to the schools.
2. A critical review of tables.
3. An agreement on professional terminology.

This survey has been undertaken with the use of the guides prepared by the F.N.I.F. for the study of schools and the results are, therefore, of the greatest interest to us. It was originally planned as an appendix to the study which the F.N.I.F. is making in the field of advanced education for nurses. This idea is now given up — partly because it will take some time still to complete the Scandinavian survey; partly because it is intended to be a comparative study which is not the case with the work which the F.N.I.F. is doing at present, which rather has the character of suggesting a method of studying, illustrated with examples of schools in different parts of the world.

It is possible, though, to make comparisons within a region which, in spite of differences of opinion, in many ways has things in common with regard to race, language, upbringing and standards of living; and perhaps, most important of all, with regard to mental attitude towards nursing and preparation for nursing. When it appears finally, it will be of wide interest, not only to the schools themselves, who naturally benefit during the process, but also to similar schools in other countries. From the point of view of the F.N.I.F. it is of the greatest value to have our working tools tried out.

As far as an agreement on terminology is concerned this is, if not the most difficult problem, at least one of the hardest when working in groups representing different nationalities. When this difficulty can arise in a fairly homogeneous group, it is understandable that it complicates international work. Having accepted English as the main language in which to express ourselves in international cooperation, it is a matter of importance to define and accept a certain professional terminology that can be mutually accepted by nurses from the countries where English is the mother tongue as well as by nurses who have English as an adopted language, often acquired specifically through professional studies in other countries.

—*I.C.N. Newsletter,* Oct. 31, 1953.

# Nursing Profiles

**Phyllis Jane Lyttle** is the superintendent of the Nursing Division of the Department of Public Health of Nova Scotia, culminating 15 years of devoted service in public health nursing in that province. Following graduation from the Payzant Memorial Hospital, Windsor, N.S., Miss Lyttle returned there to work as operating room supervisor, then assistant superintendent. A short period of private nursing convinced her that her greatest interest lay in working with those who were ill in their own homes, especially in the relatively remote rural areas. During the next ten years Miss Lyttle worked on Cape Breton Island, attending over 600 home confinements. Over unpaved roads, that were not even ploughed out in the winter, she travelled in any available conveyance. In 1948 she was appointed regional supervisor of public health nurses, becoming acting superintendent in 1950. A Zonta Club member, Miss Lyttle loves flowers and all outdoor activities.

*N.S. Bureau of Information*

PHYLLIS J. LYTTLE

**Margaret Ellen Cameron** is the new superintendent of nurses and director of the school of nursing of the Winnipeg General Hospital. A native daughter of Winnipeg, Miss Cameron engaged in private nursing for four years following her graduation from W.G.H. then decided to work in the United States. She secured both her bachelor's and master's degrees from Teachers College, Columbia University, during the time that she was science instructor, then director of nurse education at St. Luke's Hospital, New York. She returned to the Winnipeg General Hospital as assistant superintendent of nurses in 1952.

Miss Cameron has had much experience in professional association activity. For three years she was secretary of the Committee on Measurement and Guidance of the New York City League of Nursing Education and later chairman of the Production Committee on Records of the National League of Nursing Education's Department of Services to Schools of Nursing. She holds membership in Zonta International and the University Women's Club.

*Darue*

MARGARET E. CAMERON

**Captain Gladys McGregor** has been named director of nursing at Grace Hospital, Winnipeg, where she was formerly clinical instructor. She succeeds **Major Mabel Crolly** who has been appointed assistant superintendent and director of nursing services at Grace Hospital, Windsor, Ont.

**Lillian Irene Houseman** has recently been appointed chief stewardess with the Trans-Canada Air Lines. Born and educated in Central Butte, Sask., Miss Houseman is a graduate of the Toronto General Hospital. After a brief period in general and private nursing, she joined T.C.A. as a stewardess. For the past seven years she has been stewardess in charge at the Malton Airport.

Miss Houseman honestly admits that her participation in outdoor sports is largely of the spectator variety. She enjoys skating, a limited amount of skiing, and finds great pleasure in needlework and knitting.

Lillian I. Houseman

**Marjorie Jenkins** is back at the work she loves. She was recently appointed superintendent of the Home for Incurable Children in Toronto. A graduate of the Hospital for Sick Children, Toronto, and of the McGill School for Graduate Nurses, she has spent the greater part of her professional career laboring among and for children. Following two years as instructor in her own school of nursing, Miss Jenkins took charge of the children's department at the Ottawa Civic Hospital. Several years later she became superintendent of the Children's Memorial Hospital, Montreal, moving on to a similar position in the Children's Hospital, Halifax. It is only in recent years that her care has been extended to adult patients. She was in charge of the out-patient department at Victoria General Hospital, Halifax, for nearly five years. During the past year she was health instructor and students' counsellor at the Ottawa Civic Hospital.

Over the years, Miss Jenkins has worked tirelessly for the advancement of the professional side of nursing. Besides being president of the Registered Nurses' Association of Nova Scotia for three years and treasurer of the Canadian Nurses' Association for four, she has served on innumerable committees. She was chairman of the committee sponsoring the Nurses' Official Directory in Halifax for five years. Apart from nursing affairs, Miss Jenkins has given an excellent example of good citizenship by participating actively in community interests. She was on the board of governors of the Halifax Conservatory of Music and was a member of the Halifax Choral Union. She has always taken an active part in the Women's Canadian Club.

Elizabeth Smith

**Elizabeth Smith** has retired from active nursing and from the post she has held for the past ten years as director of nursing services with the Department of Public Health of Saskatchewan. A graduate in arts from the University of Saskatchewan, Miss Smith taught school in that province for several years before beginning her training at the Vancouver General Hospital. Following graduation in 1926, when she received both the general proficiency and medical nursing medals, she returned to Saskatchewan and joined the school hygiene branch of the Department of Education. Her former teaching experience was put to good use when she took over the responsibility of the health program in the normal school in Moose Jaw and later in Regina.

In 1934 Miss Smith was awarded the first Florence Nightingale Scholarship offered by the Canadian Nurses' Association. She qualified for her public health certificate at the University of London at that time. In 1946 she was awarded a Rockefeller travelling fellowship. Miss Smith was president of the Saskatchewan Registered Nurses' Association for three years and held many other posts with the association. She was presented with an engraved watch by her staff when she retired.

## *Public Health Nursing*

# Anticipatory Guidance

Charles H. Gundry, M.D., Trenna G. Hunter, B.A.Sc., Ruby A. Kerr *and* Beverley E. Hopkins, B.A.

Anticipatory guidance may sound like a very new idea but research reveals that the British Columbia Indians of the Bella Coola tribe had elaborate methods of what amounted to anticipatory guidance. Their practice took the form of providing comforting specifics to help Indian mothers. An example is quoted from a study made by T. F. McIlwraith:[4]

> *To cause strength*: 1. Collect four pieces of bark, each from a different tree where a grizzly bear has scratched. Place them in the infant's washbowl, then warm them at a fire and rub over his body. This ensures him the strength of a grizzly bear.
>
> 2. Collect four water-smoothed green stones from the river. Place them in the infant's washbowl, then warm them at a fire and rub over the body. After four days return the stones to the river.
>
> 3. Warm the body of an octopus, beaver, or wolverine in the smoke of a fire and gently press the carcass against an infant's body saying, "Please, may he be like you." This provides the child with the strength of the animal used.

There were other specifics commonly employed: to cause long life, to cause bravery, to cause modesty, and respect for one's elders. In addition to the confidence the Bella Coola mother derived from these traditional ceremonies, she had the support of a culture which approved of children.

> The Bella Coola are fond of children. Their birth is a matter of sincere rejoicing . . . The parents usually spoil their children; infants especially are never chastised and rarely rebuked.

Of interest to us in view of the emphasis placed today on the various aspects of feeding is this quotation:

> A newborn child takes the breast readily and a mother would be considered harsh indeed if she failed to suckle her infant whenever it cried, since scientific hours for feeding are not known.

In view of our changing cultural patterns today the following is interesting:

> Primarily, responsibility rests with the parents for the care and support of their offspring, but they have the advice, assistance and material aid of their relatives. Nor are these limited to the near kindred of either father or mother; all members of the ancestral family take their part.

### Today's Uncertainties

Contrast these old and well-tried principles with the many possibilities available to mothers of our day. The underlying uncertainty of conflicting philosophies of child care is one of the difficulties with which our modern mother has to contend. Indeed, mothers are exposed to so many different sorts of ideas regarding child care that they are apt to become confused and indecisive. This was brought out in a World Health Organization seminar on the mental health of infants in relation to their emotional environment which took place in Chichester, England, in August, 1952:[1]

> In a lecture on child development patterns, Professor E. Jackson, of Yale University, compared the advice given in the two best known manuals on infant care in the U.S.A. The general trend appears to be one of "enjoy your baby as he is" but this enjoyment seems

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Dr. Gundry is director of the Mental Hygiene Division of the Metropolitan Health Committee, Vancouver. Miss Kerr and Mrs. Hopkins are psychologists on the staff. Miss Hunter is the director of public health nursing with the M.H.C.

> to be somewhat self-conscious, less spontaneous than in certain other countries. In one of the discussions, the reluctance of many American parents to be authoritative was described.

This quotation points to a lack of confidence in their training methods on the part of present-day parents which would have been unthinkable for the Bella Coola. To further illustrate the differences prevalent today here is another quotation from the same seminar. Again we cannot help but contrast this with the Bella Coola mothers who were able to rejoice at the birth of children:

> Professor D. R. MacCalman, of Leeds, presented information concerning a study in an industrial area. It seems that British families are more concerned with discipline than those in France or the U.S.A. and that it is not always easy for the mothers to enjoy their children.

Partly because of all our uncertainties of today there has arisen a great appetite for mental hygiene. Wholesome though that is, basically there is the danger that it will be misunderstood and taken to be a set of fast-healing principles that are able to cure almost anything. Along with this enthusiasm there may be a lack of realization of the difficulties that are encountered in achieving desired results. It is only by people coming to recognize the limitations of mental hygiene that its principles can be put into more profitable use.

### A New Approach

To illustrate one attempt that has been made to point out some of these limitations we shall consider our Mental Hygiene Division's work in the Child Health Centres in Greater Vancouver. This work commenced a few years ago with the idea that this would be a new area to work in, where we might be able to measure not only the value of the work done but also to evaluate the nature of the obstacles. Following two years of this experiment we wrote an article entitled "Anticipatory Guidance in Child Health Centres" in which we tried to review and assess our attempts to introduce anticipatory guidance into these centres.

That article was an account of an experiment in methods that would introduce more mental hygiene into our child health centres, or well baby clinics as they are sometimes called. In addition to the doctors, these centres are staffed by some 100 public health nurses upon whose shoulders the program of the Mental Hygiene Division largely rests, as it is they who are instrumental in referring most of the cases that come to the mental hygiene clinics. They are largely responsible for supervising the recommended treatment and carrying out follow-up procedures. Through this part of their work the instruction in mental hygiene that they have received as students is put into practice and extended. They are in consequence a group who already have a growing relationship to the field of mental hygiene.

The philosophy of child care and its potential importance in good preventive mental hygiene, implicit in Dr. David Levy's$_3$ dictum "the way a mother feels about her child, her attitude, is at least a significant if not the most significant influence in the development of the child's personality," was the basis of an attempt at working out a theory for the practice of anticipatory guidance. If the public health nurse could become aware of a mother's adverse attitude before it had affected the infant's behavior and could modify it through her relationship with the mother, that would be truly preventive work. To quote from our earlier article:

> According to the theory of anticipatory guidance, a nurse's maximum effectiveness in mental hygiene teaching in the child health centres should depend upon her ability to distinguish the mother whose attitudes are such that they may lead to developing a strained or weak relationship with the baby—that is the mother who may appear to be unsure, tense, anxious, critical, fussy or inconsistent. We want nurses to be able to spot unwholesome maternal attitudes before problems develop. We want them to think back from symptom to relationship to maternal attitude. In the past

this process of thinking of the cause and preventing the problem has not been emphasized enough. Instead the focus has been on offering help *after* problems have arisen. We have come to the stage where mothers are asking questions about habit difficulties and symptoms that might be due to tension. In recent years the nurses' answers to these questions have been increasingly well informed and reassuring. Thus, they have been making helpful contributions to the correction of very early problems but they have rarely, as far as we can see, been advancing to the point of anticipating these problems. It was the Mental Hygiene Division's desire to broaden the nurse's role in the child health centres by introducing this anticipatory, really preventive approach.[2]

### THE PSYCHOLOGISTS' ROLE

It was decided that the two psychologists attached to the Mental Hygiene Division should work with the nurses in the child health centres to assist in spotting problems and interviewing mothers. The presence of a psychologist at the centre helped to keep the importance of the emotional state of the mother in the foreground of the nurses' minds. Several different methods were formulated for referring cases to the psychologists and carried out experimentally for a time. One method was direct referral by the nurse, another was by the doctor. A method that was soon discontinued as unsatisfactory was having the psychologist sit in on a nurse's conference with the mother. A third person interfered with the rapport between the other two and there was no casual or natural way for the psychologist to follow any leads that she might pick up.

At the time this experiment was being started a new child health centre was being opened in which some modifications of the ordinary routine were being introduced. The same nurse was to interview a mother each time as a means of giving the latter the support of a continuous relationship. The emphasis was to be less on standards and more on individuality and the emotional well-being of mother and child. In this clinic the psychologist was to be used on a consultive basis to be called in after some initial preparation by the nurse.

### TYPES OF REFERRALS

Most of the referrals to the psychologists proved to be early mental hygiene problems rather than anticipatory guidance. The mothers had not been sent because of their attitudes but because they had complained of the child's behavior or sought advice on some problem. It became evident that it was still easier to have a chance to intercede in cases where the problems were recognized in the children instead of in the mothers. It has also been hoped that at the end of the experiment we could evaluate the five methods of referral to decide on the most productive one. However, no one method has stood out as being the most satisfactory from the point of view of collecting cases.

We feel that it is worthwhile to continue this work because of the opportunity it affords to draw attention to mental hygiene principles and demonstrate their rightful place in such a setting. The majority of the nurses have come to accept the psychologists as a part of the clinic staff and to accept mental hygiene principles as a necessary ingredient of a child health centre conference.

We have recently been requested to review this experiment with the focus of attention on the period since our first summary was presented. Although we were not really ready to draw conclusions about this whole program as yet, we are glad that interest has led to our review in this phase of our work. A survey of the past two years quickly reveals changes and modifications in the program since we first started.

### CHANGES AND MODIFICATIONS

Many of the old difficulties still exist. Foremost among these are the individual differences in our public health nurses. The differences in their training and, more important, in their interest, influence any experimental program but particularly one dealing with mental hygiene. Many nurses are still not confident enough to follow up leads pertaining to emotional problems but prefer to stick to the more cut and dried physical questions that are presented in child health centres. Happily, however, many of our nurses are acquiring a good working knowledge of mental hygiene concepts which is giving them the additional confidence necessary to branch out a little while interviewing mothers. The principles of interviewing are being used with more awareness, making the conferences more revealing. We recognize the fact that the increasing awareness and use of these techniques may uncover problems that will require more time to discuss. At the same time, the nurse is still faced with the problem of having to meet the needs of the large number of mothers attending a centre. For the conscientious nurse there will always be this pull between the time to spend on one mother and the needs of the clinic situation as a whole.

Another difficulty that remains with us is the physical settings of most child health centres. Usually, they are crowded, noisy, and confusing. In most locations the psychologists have been given a little better working space than the nurse by the provision, where possible, of a small room or corner. This provides the necessary atmosphere of semi-privacy which is so helpful in establishing some degree of rapport.

On the whole, the public health nurses have shown more initiative in presenting plans of their own to promote this experiment during the past two years. A few months ago the nurse in charge of one of the child health centres requested that a psychologist attend her clinic. In this particular clinic, the nurses felt the need of this auxiliary service and have made good use of it on a consultive basis — probably the most economical and effective use that can be made of the psychologist's time.

This particular clinic functions most successfully. The public health nurse gives the mother considerable support and interpretation before the appointment is made to see the psychologist. Thus, the mothers are well prepared to talk to some outside person and usually have some insight into their difficulties. The public health nurses have been striving to have the psychologists accepted by the parents as a recognized part of the public health team. They first introduce this idea when they are making their routine visits to all mothers following notification of new births. The introduction is usually a casual reference to the fact that there is a psychologist on the staff who is available for extra assistance at any time. This helps to make the mothers aware of the early stage at which we are ready to offer guidance.

Another way in which the psychologist has been made a part of the service has been through routine referrals to her. At about one year of age, attendance at our clinics becomes more infrequent. It is during this second year that many a mother finds that her hitherto tractable infant begins to exercise a newly discovered will of his own. Some kind of discipline has to be instituted which, in turn, often brings added insecurities to the parents.

A routine referral was not our original conception of anticipatory guidance as such but was a practical adaptation of the idea in order that more mothers would be seen. A general discussion with the mother about her baby's development when he is reaching his second year might "anticipate" later behavior difficulties. It is true that the relationship of the child and mother is marked by crises during the preschool period but a discussion about the so-called "normal" behavior and ways of promoting this gives the mother added confidence and security when she meets difficulties.

Thus was evolved the idea of having the nurse mention to each mother upon completion of immunizations, that there was a psychologist attending her clinic. A brief outline of her function was given and the mother was encouraged to have a talk with her. The results have been, on the whole, quite encouraging. Several mothers have come in to see the psychologist because it was routine and have remained to discuss their philosophy of child care and have often brought up many of their own difficulties. In this way, we have made some progress in discussing topics with mothers that might not, otherwise, have been brought up or might have remained hidden until they had assumed more serious aspects.

### APPOINTMENTS

One major change that has come about during the past two years has been the arrangement of appointments in child health centres. Previously, appointments were made for every quarter hour and they were taken in turn by whichever nurse was free at the time. In our first article, we noted how much more effective a nurse's interview could be if she were available to the same mothers each time, thus giving her an opportunity to establish some kind of continuing relationship that would eliminate a regular review of significant history. Furthermore, the mother would be more willing to discuss her attitudes and feelings as she grew to know the same nurse on each visit. Some of our child health centres have changed to this system.

It is difficult to work out a system of appointments that completely meets the needs in such a variety of situations. Although we consider the new arrangement has great advantages over the former plan, administratively it has its drawbacks. On a nursing staff of 100 nurses, absenteeism is a factor that must be considered and this presents a real difficulty when such a personal relationship has been developed between a nurse and a mother. In a generalized service there are other obligations that may necessitate a nurse being somewhere else on a clinic day. In addition, during the actual clinic operation, one nurse may have several broken appointments while another may have too many appointments for that particular afternoon. However, there are difficulties in almost any system and we feel that the advantages offered by this new one outweigh the disadvantages.

### KINDS OF PROBLEMS

An examination of the kinds of problems referred directly to the psychologists would indicate that we are still seeing chiefly early mental hygiene problems. However, we have also had quite a few referrals that could be considered anticipatory guidance. These are largely instances where the mother has complained of behavior that appears normal to us with the problem lying in the mother's attitude. A typical example of this is seen in the mother whose three-year-old son was aggressive towards the other children, was disobedient, requiring constant supervision, and was generally overactive. The mother described herself as being unable to cope with her boy. Examining this behavior more closely it appeared to be that of a healthy child who was naturally active and independent. Following some discussion of developmental stages the nurse was able to continue working with this mother, discussing and interpreting the little boy's behavior, thus reassuring the mother and changing her attitude towards him.

This short summary illustrates that some guidance is being given. In a considerable number of instances we have been able to discuss maternal attitudes before they have affected the child's behavior. It would be asking a great deal of the public health nurses to expect them to make rapid steps in this direction but the basic idea seems feasible and with continued interest and education of the mothers, more headway should be made.

There are some features that seem encouraging. There is a zone of interest around the work being done by the psychologists that is emphasizing mental hygiene. The fact that their services have been requested at some of the clinics and have been used pretty effectively indicates this. With a continuation of this program the emphasis will swing further from the child's behavior towards the mother's attitude. The use of the routine referral, previously mentioned, has given us a group of mothers who otherwise we would not have seen. Certainly any opportunity to talk to mothers about developmental procedures seems worthwhile. So the term "anticipatory guidance" has assumed a more elastic meaning over the past two years and our whole experiment has lost some of its formality as we have tried to deal with the limitations that have been discovered. There is still much to be accomplished but the widening acceptance and understanding continues to provide the necessary encouragement.

**References**

1. Chronicle of the World Health Organization. Vol. 7, No. 2, p. 40.

2. Gundry, C. H., Hall, B. E., Hunter, T. G. Anticipatory Guidance in Child Health Centres. *Public Health Nursing,* July, 1952.

3. Levy, David M. Observations of Attitudes and Behavior in the Child Health Centre. *American Journal of Public Health,* Feb. 1951.

4. McIlwraith, T. F. The Bella Coola Indians. U. of Toronto Press. 1948.

## In the Good Old Days

(*The Canadian Nurse* — February 1914)

"The function of the suprarenal capsules or adrenal glands in the body economy is as yet a matter of theory but it is fairly certain that their presence is necessary to life. We do know that if they become diseased a striking change occurs in the individual. The symptoms were described first by Addison after whom the condition is named."

* * *

"In the face of the direct evidence obtained by the school nurse — that over 50 per cent of the children needed medical attention — it was no wonder that our Board of Education voted to make the medical inspection a semi-annual affair and promised to aid the work financially. The report to the Board was somewhat of a surprise to the members as they thought that with the pure country air and better housing conditions defects would not be found among country children."

* * *

"Poisons of the kind formed in mouths that have not been kept as free from bacteria as possible, especially where there are numerous decayed teeth and discolored stumps, are particularly dangerous to delicate nervous systems. Such toxins may by themselves be quite strong enough to so affect the nerve tissues that the slow poisoning to which the latter are thus subject ultimately brings about a neurasthenic condition."

* * *

A resolution that was sent to the secretary of the National Sanatorium Association by the Graduate Nurses' Association of Ontario read as follows:

"This Association protests against the custom of placing women in nurse's costume in stores and other public places to sell Christmas stamps. This reflects unjustly upon nurses, especially as the report has been received that some of these saleswomen are guilty of unladylike behavior."

## November 11, 1953

On November 11, 1953, it was my privilege, on behalf of the Canadian Nurses' Association, to place a basket of yellow and bronze chrysanthemums at the Nurses' Memorial in the Parliament Buildings in Ottawa.

I was met at the door by a Commissioner who was wearing medals of the First World War. He looked up smartly and said, "For the Nurses' Memorial, Ma'am?" I said "Yes," and he proceeded then to carry the flowers to the Memorial for me. We stood for a couple of minutes in silence, then he looked up and said, "You would know Miss Gunn?" I nodded. He continued, "I was in the Guard of Honor when she dedicated this Memorial. It was a grand day. I suppose you know Colonel Smellie, too." He said, "The week before she went overseas in the last war she came to me and told me that she was going away and that she expected me to see to it that there would never be faded flowers at the Nurses' Memorial. You can be sure that I did as she asked."

I felt very humble as I went towards the Cenotaph where the main functions for the day were being held. I think it was the human touch of this kindly Commissioner that impressed me most on this 11th of November.

— Kathleen Bayley

# A Practical Look at the Team Concept

BEATRICE AINSLIE

CONSIDERABLE HAS BEEN WRITTEN on the team concept by those involved in nursing research. Many of today's advantages have resulted from the untiring energy and enthusiasm of thought of this group of educators. Perhaps now an article, by one who has actively participated in this type of research and has also played an active physical as well as mental role in institutional nursing for several years, might contribute in some small way to broadening the practical application of this concept.

A brief but, I believe, accurate definition of the team concept is given by Miss Marion D. Cleveland, who says, "The team method of patient assignment is a plan whereby professional and non-professional personnel work together in planning, giving, and evaluating patient-centred nursing care . . . The objectives are better care for the patients, better use of personnel, and greater job satisfaction for all nursing personnel."

I think everyone engaged in institutional nursing today realizes the necessity of this concept. With hospitalization costs forever on the upgrade, with the patient forever bearing the financial brunt, and with the basic nursing ideal being to bring aid — mental and physical — to the patient, we are drawn to this idea from necessity. Although the last half century has brought relief to many nursing situations, it has also brought many new problems. Whereas 50 years ago, a nurse's day began when the sun came up and ended when it went down — and was filled with bathing the patient, cleaning and dusting his room and preparing his meals, making poultices and stupes — today it is likely to begin with the nurse drawing a blood specimen, remembering to withhold a patient's breakfast for a special test, preparing a special tray for the test, squeezing his breakfast and bath in after the test and before he is snatched away to x-ray for the remainder of the morning. Multiply this by 20, add a dozen questions from student nurses, medical students, attendants, social workers, visitors, telephone callers; make a few appointments for more tests, a requisition here, a complaint there — a hard-boiled egg here, cold coffee there, no sugar, no breakfast, why wasn't this done, and when will that be done, doctors' rounds at 10:00 a.m., a meeting with the supervisor regarding the team concept — and you have just had a tolerably quiet routine morning on a quiet ward.

What's this? You don't want to attend the meeting? Aren't you interested in the team concept? Nowadays, you see, we not only attempt to give comfort to those physically and mentally handicapped but attempt, hand in hand with medical science, to cure or at least improve this state of being. To accomplish this ourselves, to teach it to those working with us and to those who plan to follow us is an overwhelming task, especially in a 40-hour week.

Florence Nightingale used the team concept. In her aloneness, with but a handful of workers, she was forced to put all available helpers to work to the limit of their individual capabilities — lay and professional alike. So how different is this concept today? Only in the aspect of the delegation of duties, I think. When she founded a nursing school on her return from the Crimea she was faced with the problem of a small budget and much to be done. Following the seniority pattern, the newer members were unanimously

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Miss Ainslie has worked for many years as head nurse on a medical ward in a large hospital.

elected for the more menial tasks. This period was termed an apprenticeship whereby, if it was found that one could perform manual labor with dexterity and caution for inanimate objects, one could in time progress to the stage of performing in the same way for the animate. There is a certain wisdom behind this method, for obviously those unable to handle the first stage should never be allowed to cope with the second. We are certainly wrong if we think that every human being does pass the first stage!

As the years went by, with the emancipation of woman and the improvement in living standards, it was found that the first test could be passed by most apprentices in a very short time. Because full-fledged nurses were urgently needed, their actual nursing knowledge had to be acquired as quickly as possible. The nursing educators, with this in mind, have hired paid lay personnel to do the manual tasks. Somehow in the nursing school there evolved a wide margin between the professional and non-professional worker. The nursing staff, held responsible for patient care, kept complete jurisdiction regarding every article necessary for patient care. They folded the linen, sterilized the basins, ordered supplies and did many other similar tasks directly themselves. They trusted no one else's judgment in these matters.

Then came the wars, and the greater demand for industrial, public health, office and technically trained nurses. Patients' demands led to increased numbers of hospitals. Somehow the number of nurses being graduated just did not fill the positions vacant. And, as always, when the demand exceeds the supply, the price of the supply went up. Nurses wanted shorter hours, more pay, more benefits, pensions and so on ad infinitum. Many of these demands have been answered but the shortage still remains. Because of this shortage we are back with Miss Nightingale — we, too, are forced to put each person to work to the limit of his or her individual capabilities, lay or professional, to accomplish our basic ideal of giving aid to the suffering.

This situation has been recognized for many years in small hospitals in out of the way areas. Lacking facilities in both their hospitals and communities, and unable to meet the high salary demands, small institutions have been forced into this situation much sooner than the large city and university hospitals. I doubt that many of these small hospitals realize that the team concept has evolved within their walls. Probably those involved have not had time nor felt their importance enough to recognized and write about it. Also in the large city and university hospital there is a certain professional jealousy felt. We of the university centres are sometimes loathe to acknowledge that much of the work could be done by properly guided and interested lay personnel. This, I sometimes think, is particularly evident in nursing schools with high standards acknowledged in their own country or with world-wide reputations.

Many of this group now for the first time have been forced into the same situation as of old. There are just not enough nurses available, no matter how attractive the facilities. The 40-hour week seems somehow to have been the straw that broke the camel's back. Considering that ten years ago each member of the nursing staff worked 54-60 hours a week, one can see that 14-20 hours less for each member requires an increase of almost one-third in nursing personnel. Moreover, in the last ten years most of these hospitals have increased their patient capacity by at least one-third again, thereby adding more strain on personnel. This has made necessary a reassessment of our services to the public. The practical application of the team concept seems to be the most logical solution to our major nursing problem today. Not only must this concept be applied but it *must succeed* if we are to fulfil our basic nursing ideals.

In the sponsored research carried out to date the method has been to take a segregated group of patients and a chosen group of staff — professional and lay — and apply the principle of maximum patient care. The principle has been applied but it has required special meetings for selection of professional staff, special meetings for selection of lay staff, special classes for both! These meetings and classes are all time consuming and, therefore, expensive. Is this actually the proper interpretation of the team concept?

In one New York hospital on a surgical ward where this research has been conducted for some time, the care of 29 patients for a 24-hour period is provided by a salaried staff of 24 personnel, approximately half professional and half lay. In another New York hospital the average work load, by the research group, is two patients to one salaried staff worker. This should improve patient care in the hospital situation theoretically but not practically when the patient receives the hospital bill. Since the team concept arises out of our shortage, how could the general public or any publicly owned institution hope to acquire or afford this number of nursing service workers? Also, if it still holds true that the less one does, the less one wants to do, how will workers trained in this environment feel when their work load is increased, as it inevitably will be?

These questions are being asked, not by one, but many nurses in institutional services today. If we are to succeed with our team concept could we not, in our research stage simply convert any given ward with its given personnel — small or large in number as it may be — and have the leader of the group apply this team concept to each member of her present staff? Could she not adapt each member to newer and fuller responsibility as she, with their approval, knowing and understanding them, sees them fit to carry it?

The team plan under which I worked fell apart after less than a month's trial, because one of our group fell ill, and the student nurses who were included started classes. Therefore we could not have two teams because there were but three people left! Both team leaders remained however, and continued to share and divide the work load as they saw fit, and as they had done previously. I'm sure the patients did not notice the difference in nursing care during this period. Then, too, it seemed a shame that our project had fallen through under one of the usual stress situations. If this concept is to live and thrive we must make it flexible and durable under the greatest stress tests and not have it collapse like a balloon the moment it meets foul weather!

We nurses do gain much from these sponsored research groups. It is, therefore, unfortunate that nurses reading articles about such research are often alienated by certain statements appearing in the reports. For example, reporting on one such group, Amelia Lieno says, "A daily team conference . . . information exchanged . . . progress evaluated by all members of the team . . . during the afternoon rest period." Many nurses reading this article will ask, "What if a new patient is admitted at this inconvenient time? What if someone becomes nauseated or slips into pulmonary edema?"

If this research group found time in which to sit around and confer during daily rest period they are among the few in the practical nursing field today who could. Surely there is some necessary automatic manual task that could be accomplished by at least one or several members of this conference group while they exchanged information. Most nurses could suggest a few tasks that would brighten up the patient's environment, such as cleaning infusion standards, side rails, bedside tables, or even sorting and rearranging flowers. Or perhaps they could make up chart forms or routine daily forms of one sort or another. This is precious time — it will never pass this way again! Considering that in many present-day situations two or three personnel are responsible for the care of 20 to 120 patients, are they any the less well informed if they exchange their information while cleaning and sterilizing instruments rather than sitting in conference? Statements in research articles such as quoted above cause many busy nurses to ridicule the entire article despite its true value or the importance of the research done.

Wherever there is the spirit of the team concept (namely, to give the maximum patient care at a minimum monetary cost with the greatest job satisfaction to all personnel involved), wherever a leader appreciates the mental and physical talents of those working with her, there is rarely dissatisfaction among the personnel, no matter how few are available to perform the work at hand. Whether or not we attempt to work as a team under research sponsored conditions, I see no reason why all of us who teach cannot do everything within our power to apply it to our present working situation. We all have lay personnel with whom our rapport is such that they, understanding our situation, would accept new responsibilities with fullest appreciation for improved patient care. The inclusion, rather than exclusion, of these people is bound to result in adult team play guaranteed to win.

That we need more team leaders is definite. That we need more nurses is definite. Therefore that we should strive to teach all of our students to be team leaders in the future seems a very acceptable theory. That we will have 100 per cent success is doubtful but that we could strive for this per cent is not so dubious.

### REFERENCES

1. Cleveland, Marion D. The Team Method of Patient Assignment. *The Quarterly Magazine, Alumnae Association, Presbyterian Hospital School of Nursing, 47:4,14.*

2. Kuntz, Mary N., and Rogers, Mary. Planning Assignments for Nursing Teams. *American Journal of Nursing,* Sept. 1950.

3. Lieno, Amelia. Organizing the Nursing Team. *American Journal of Nursing,* Nov. 1951.

4. Perkins, Dorothy, and Heslin, Phyllis. Nursing Service and Nursing Education Advance Together with the Team Plan. *American Journal of Nursing,* Feb. 1952.

# In Memoriam

**Winifred (Simpson) Bannister,** a Toronto-born graduate of Lakeside Hospital, Cleveland, Ohio, died at her home in West Vancouver, B.C., on November 11, 1953, at the age of 74.

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**Robena Frances Brown,** a graduate of Miramichi Hospital, Newcastle, N.B., died in Florida on November 28, 1953, in her 41st year. Miss Brown had been active in private nursing for many years in Moncton, N.B., prior to her untimely accident.

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**Lily (Casserley) Crane,** who graduated from St. Michael's Hospital, Toronto, in 1905, died at Pasadena, Calif., on May 26, 1953.

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**Sarah (Payne) Dempsey,** who graduated from Rockwood Hospital, Kingston, Ont., in 1914, died in Renfrew, Ont., on November 24, 1953, at the age of 65. In 1915 Mrs. Dempsey went overseas with the Red Cross, later transferring to the Canadian Army Medical Corps. She served in England and France before being invalided home in 1919. She worked as principal woman immigration officer at Quebec prior to her marriage in 1923.

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**Nina Grant,** who graduated from the Aberdeen Hospital, New Glasgow, N.S., over half a century ago, died in New Glasgow on November 5, 1953, after a lengthy illness, in her 75th year. Following graduation, Miss Grant served on the staff of Aberdeen Hospital for over 26 years, 12 of them as superintendent. After she resigned that post she took over duties as business manager until ill health forced her retirement.

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**Marion Robina Hinde,** who graduated from the Winnipeg General Hospital in 1937, died in Wingham, Ont., on November 9, 1953. Miss Hinde took post-graduate work at the Manhattan Eye, Ear, and Throat Hospital and had received her certificate in teaching and supervision from the University of Western Ontario. Prior to her illness she was on the staff of the Freeport Sanatorium, Kitchener, Ont.

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**Alma Little,** a 1953 graduate of St.

Paul's Hospital, Saskatoon, Sask., died recently in a car accident.

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**Marie (MacLeod) MacKenzie,** a graduate of Boston General Hospital, died in New Westminster, B.C., on November 21, 1953, after a lengthy illness. Mrs. MacKenzie had served as matron of the Prince Co. Hospital, Summerside, P.E.I., before going overseas with the C.A.M.C. in World War I.

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**Bertha Marsden,** who for 19 years was in charge of the Infants Hospital, Vancouver, B.C., died on November 18, 1953, after a prolonged illness. For a time during World War I, Miss Marsden was matron of the Resthaven Military Hospital at Sidney, B.C.

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**Emma J. Mitchell,** who graduated with the third class from the General Hospital, Saint John, N.B., in 1895, died there on December 4, 1953, aged 92 years. Two years after graduation, Miss Mitchell was appointed matron of S.J.G.H. For several years she combined the duties of hospital administrator and superintendent of nurses. When it became necessary to separate the two functions as the hospital grew, she continued in the former capacity until she retired in 1928. She was a past president of the hospital alumnae association and of the Saint John Chapter of the Registered Nurses' Association.

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**Dorothy M. Pelton,** who received her training at the Woman's Hospital, Detroit, died suddenly on November 18, 1953. Miss Pelton had resided in Woodstock, Ont., since her retirement.

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**Dorothy Belle (Miller) Tait,** who graduated from Royal Columbian Hospital, New Westminster, B.C., in 1928, died in Vancouver on May 6, 1953.

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**Annie Bertha Wells,** who graduated from St. Boniface Hospital, Man., in 1925, died in Winnipeg on November 4, 1953, in her 65th year. Miss Wells had worked at Clearwater Lake Hospital, The Pas, Man. In 1949 she entered the deaconess training school in Toronto but owing to ill health could not finish her course.

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**Lucille Worden,** who graduated from Royal Columbian Hospital, New Westminster, B.C., in 1953, died in the crash of an airlines mercy flight plane on October 21, 1953. She was 21 years of age.

## The Loneliness of Illness

In Evelyn Pearce's recent book entitled "Nurse and Patient" there is a chapter that reminds us again of the need for sensitivity on the part of the nurse if she wishes to fulfil her destiny in ministering to man's needs. The author talks of the innate loneliness experienced in illness that springs from the feeling of being different from other people by the mere fact of being ill. The patient is surrounded by so many discomforts that no healthy person can fully comprehend that he is further isolated and his loneliness increases.

The nearness of another human being is of large significance in these cases and any little attention by the nurse will help. "A smile, some comforting words and the knowledge that the nurse will be near enough to hear him if he calls can be most reassuring."

Miss Pearce feels that the loneliness of a sick child can rarely be appreciated by an adult. A small child will follow the movements of the nurse with his eyes, hoping so strongly that she will come near him and dreading that she will go out of his sight and he will be left alone. It is comforting and relieves this very real fear if the nurse will go often to the child's side to offer some little attention, assuring him that she will not go far away and will come back soon. This, of course, she must not neglect to do.

Loneliness can be a potent force in determining the course of an illness. Particularly in the case of infants, young children, and old people, the nurse should strive to understand their feelings, to enter into them and dispel their sense of aloneness whenever possible.

Every man's work, whether it be literature or music or pictures or architecture or anything else, is always a portrait of himself, and the more he tries to conceal himself the more clearly will his character appear in spite of him. — Samuel Butler

# News and Echoes

*from*

*Your* NATIONAL OFFICE

## Banff—June 7-11, 1954

Do you know:

That now is the time to pre-register for the 27th Biennial Meeting of the C.N.A.? That By-laws affecting all C.N.A. members will be discussed at the meeting? That special trains will be leaving from Montreal, Toronto, and Vancouver? That you can bring your relatives and friends with you? That Banff is the camera fan's paradise? What a real ranch-style dinner is like? What it feels like to bathe in a warm sulphur pool? — If you do not, then come to Banff in June and find out! If you do, you will be there!

## Newfoundland

The C.N.A. is very grateful to the Manitoba Association of Registered Nurses for their generosity in allowing their very busy registrar, Miss Lillian Pettigrew, to spend two weeks in Newfoundland. As has been previously reported, the Newfoundland Graduate Nurses' Association saw their Registration Act passed by the Legislature earlier this year. Miss Pauline Laracy has been appointed as registrar. She is setting up the mechanics of administering the Act. In order to assist her in her orientation to association activities, Miss Pettigrew was asked to spend two weeks with her and graciously consented to do so. We are looking forward with pleasure to welcoming the Newfoundland nurses to our General Meeting in June.

## Educational Policies

In order that the Statement on Educational Policies of the C.N.A. may be distributed widely in a convenient form, they have been printed in a two-fold pamphlet with an introductory statement prepared by the Core Committee of the Committee on Educational Policy. By the time this issue of *The Canadian Nurse* is published, National Office will already be distributing them upon request.

## Student Nurses' Activities

Recently we have had the privilege of addressing several groups of student nurses with the purpose of telling about the functions of the International Council of Nurses and the C.N.A. What has impressed us is the interest shown by these young people in our professional associations and their eagerness to take part. If this enthusiasm is present in the undergraduate years, why and when does it evaporate? When one thinks of the difficulty in getting active participation in district or chapter activities from the recent graduate, it seems to indicate that somewhere along the line we are missing an opportunity to nurture this enthusiasm. It does bear thinking about. Perhaps as student attendance at our Biennial Meetings increases, as it has every appearance of doing, we shall discover some means of bridging the gap.

## Hawaiian Holiday Tour

We have just heard from the Chairman of the C.N.A. Transportation Committee that there has been confirmation of the tourist air fares for the post-convention trip to Hawaii next June:

CANADIAN PACIFIC AIRLINES

Leaves Vancouver, Saturday, June 12, in afternoon — arrives Honolulu same evening.

Leaves Honolulu, Monday, June 21, in morning — arrives Vancouver same evening.

*Cost*: $317.55 which includes tourist air fare, taxis to and from airports, hotel accommodation (twin beds and bath), and three sight-seeing tours. Meals are *not* included.

One last plea — *Please Pre-Register Early.*

# *Nouvelles et Echos*

*de*

*Votre* SECRETARIAT NATIONAL

### BANFF — 7 AU 11 JUIN, 1954

Vous êtes au courant n'est-ce-pas? qu'il est temps de vous inscrire dès maintenant pour le 27e Congrès Biennal de l'Association des Infirmières du Canada; que des Règlements concernant tous les membres de l'A.I.C. seront discutés lors de ce Congrès; que des trains spéciaux partiront de Montréal, Toronto, et Vancouver; que vous pouvez amener vos parents et amis avec vous; que Banff est le paradis des photographes amateurs; qu'un diner — pur style "cowboy" — vous attend et que vous connaitrez la sensation de vous baigner dans les sources sulfureuses chaudes? Non, vous ne saviez pas? Alors venez vous rendre compte, soyez à Banff en juin. Vous avez déjà goûté aux charmes de Banff? Alors vous y reviendrez, n'est-ce pas?

### TERRE-NEUVE

L'A.I.C. est reconnaissante à l'Association des Infirmières Enregistrées du Manitoba d'avoir permis à la registraire, Mlle Lillian Pettigrew, de se rendre à Terre-Neuve pour deux semaines. Comme nous l'avons déjà rapporté, l'Association des Infirmières Diplômées de Terre-Neuve a obtenu une loi concernant l'enregistrement. Mlle Pauline Laracy a été nommée registraire. Elle met en marche tout le mécanisme nécessaire à l'administration d'une loi.

Afin de l'aider dans sa tâche, l'on a demandé à Mlle Pettigrew, qui a gracieusement accepté, de l'orienter durant les deux premières semaines de son travail. Nous serons heureuses de souhaiter la bienvenue aux infirmières de Terre-Neuve, lors du Congrès de juin.

### ENONCES SUR LA POLITIQUE DE L'A.I.C. EN MATIERE D'EDUCATION

Les énoncés sur la politique de l'A.I.C. en matière d'éducation ont été imprimés en un feuillet double d'un format commode. La distribution en sera ainsi plus facile et atteindra un plus grand nombre de membres. Lorsque ce numéro de la revue sera entre vos mains, le Secrétariat National sera en mesure d'en faire la distribution sur demande.

### LES ACTIVITES DES ETUDIANTES INFIRMIERES

Récemment nous avons eu le privilège d'adresser la parole à plusieurs groupes d'étudiantes infirmières dans le but de leur faire connaître les fonctions du Conseil International d'Infirmières et celles de l'A.I.C. L'intérêt manifesté par les étudiantes et le désir de prendre part d'une manière active au programme des associations, nous ont vivement impressionnées.

Si un bel enthousiasme existe chez les étudiantes pourquoi s'éteint-il une fois qu'elles sont diplômées? Lorsqu'on pense aux difficultés que l'on rencontre dans les districts, les chapitres pour obtenir une participation active, l'on ne peut s'empêcher de penser qu'à un certain moment l'on a négligé l'occasion de nourrir cet enthousiasme. C'est un sujet auquel il faut réfléchir. Peut-être que les étudiantes qui assisteront au Congrès — leur nombre augmente de congrès en congrès — seront en mesure de nous suggérer des moyens qui éviteront cette solution de continuité dans l'enthousiasme.

### LE VOYAGE AUX ILES HAWAII

Nous venons de recevoir de la convocatrice du Comité des Voyages de l'A.I.C. une confirmation concernant le voyage à Hawaii, faisant suite au Congrès.

### LIGNE AERIENNE DU CANADIAN PACIFIC

Départ de Vancouver, samedi le 12 juin dans l'après-midi — arrivée à Honolulu dans la soirée du même jour.

Départ de Honolulu, lundi le 21 juin, dans la matinée — arrivée à Vancouver le même soir.

*Coût:* $317.55 comprenant passage classe touriste en avion, taxis à l'aéroport, hôtel (deux couchettes par chambre avec bain) et trois promenades en autocar. Le prix des repas *n'est pas compris.*

Inscrivez-vous dès maintenant pour le Congrès de juin!

### CHEZ LES NOTRES

La publication d'une nouvelle édition française de "La Garde-Malade en Chirurgie" sera bien acueillie par les institutrices qui déjà depuis longtemps réclament ce volume.

## *Focus on . . .*

## Nervous Tension

DRS. BLUMENTHAL, FUCHS AND BENNETT, writing in the October, 1953, issue of *American Practitioner,* stress the role of tension in headache: whether it alone causes the headache, whether it just brings on, or enhances an actual specific type of migraine, histaminic, hypertensive, or other type of headache. They show that nervous tension serves to build up and produce headache in a susceptible patient.

"At some time all of us come to realize that there is a limit to which we can put our physical and nervous systems. The more fortunate individual learns early in life the limits he can stand . . . and that when he exceeds these limits something unfortunate or uncomfortable happens. This usually shows up as a physical condition, such as fatigue, general nervousness, irritability, tension; or a specific symptom, such as headache, hypertension, gastrointestinal spasm, or anyone of a number of other psychosomatic symptoms."

It is unfortunate that most people do not heed these early warnings but persist in adding more strain until a more forceful warning or psychosomatic symptom develops. If the patient has exceeded his limits for a long time he will experience repeated attacks, and because habit reflexes are set up in the system, the symptoms are reproduced much more readily than they were in the beginning. The writers explain to the patient that his body is capable of just a certain amount of nervous, physical, and emotional strain every day. If he reaches or exceeds this limit, it is enough to set off a headache or other symptom to which he is subject.

It makes no difference whether the body is strained by physical exertion, by changes in fluid balance as the monthly cycle evolves, or by illness, fever, or any other factor. Added to this, our everyday life places us in situations that produce anxiety. All of these factors use up energy and create a certain amount of tension. The average patient is not aware of the effect of these strains on his bodily processes so the most important aspect of therapy is to help the patient understand himself.

"The patient himself is the only one who can apply effective therapy in the case of headache. The role of the physician is to let the patient talk, to direct his thoughts to significant revelations, and to suggest the value of a more hygienic mode of life."

The writers conclude that although medication for relief of an actual attack of tension headache may be prescribed for the patient, he should not continue to function under the same conditions of overwork, fatigue, and other strains that have caused the headache to develop. Medication will only alleviate the headache. The best cure is the positive approach and the establishment of a mode of life that will eliminate the causes of tension.

## Pictures for Patients

"The effect in sickness of beautiful objects, of variety of objects and especially of brilliancy of color is hardly at all appreciated . . . Variety of form and brilliancy of color presented to patients is an actual means of recovery . . ." So wrote Florence Nightingale nearly a hundred years ago. Yet when the artist Adrian Hill tried to introduce a little color, in the form of pictures to clean hospital walls, a shocked and outraged medical profession assured him that pictures were unhygienic, pictures were dust-traps, pictures in fact were *forbidden.*

Adrian Hill had himself been ill. He knew so well by experience the stultifying effect of impersonal hospital surroundings. His profession led him to diagnose the empty effect of the lack of even the color associated with normal everyday life.

He had saved himself from the killing boredom of months in bed by taking up his painting again. This experience eventually led him to start art lessons, as part of the occupational therapy being given in the sanatorium where he had received treatment. Teaching painting automatically led to encouraging art appreciation, and because of his own intense enthusiasm he eventually won official permission to provide well known reproductions on loan to people with long-term illnesses.

The very real interest these prints aroused led to a letter being written to *The Times* of London, England, describing this latest amenity for the sick. The British Red Cross at once invited Adrian Hill to give them more details of his scheme and soon the Red Cross Picture Library was formed. That was in 1944. Today many hospitals and sanatoria welcome the voluntary Red Cross workers who, once a month, bring a fresh supply of pictures to decorate the walls.

The excitement of the smell of a summer day to those who are destined to see nothing of it beyond a square of sky has perhaps accounted for the popularity of the heat-quivering Provençal landscape of Van Gogh. Utrillo's street scenes, Cézanne's brilliant colors, the French Impressionists, Paul Nash, all are asked for but Constable and Van Gogh's paintings are perhaps most popular of all.

— From the *Picture Post* of London.

## Undergraduate Medical Education

While it is not yet feasible to formulate international standards for medical education, it is possible to indicate general objectives and basic principles which are applicable to both pre-medical and medical studies in all countries. These objectives and principles are set forth in the second report of the Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel, which has just been published as No. 69 in the *World Health Organization: Technical Report Series.*

This report emphasizes that the primary aim of undergraduate medical education should be to give basic training that would prepare the graduate to enter further studies to qualify him for a particular branch of medicine, the most important being general practice. Pre-professional training should include instruction in *the humanities and social and "behavioral" sciences,* as well as in the natural sciences. Subsequent medical education should provide, in addition to professional (or clinical) training, studies which will enable the student to understand man in his physical, psychological, and social environment. It is, therefore, desirable that the student from the very beginning of his studies should be taught to consider the patient as a social organism, not merely as a clinical case, and that preventive and social medicine should play an important role early in the medical curriculum.

The report includes consideration of the practical application of these principles, their repercussions on the organization of medical studies, and the various factors on which successful application depends: Selection and preparation of students; the role and qualifications of teaching personnel; improved standards of medical education; and effective international collaboration.

— From *Chronicle of The World Health Organization,* June, 1953

## For Hindered Feet

Pale little feet, now iron-shod,
You never know the feel of sod,
Nor slip of sand between your toes
In brooks where country water flows.
You never climb an apple tree
From whose wide branches one may see
Green fields where spotted cattle lie
And larks go singing through the sky;
Where willows bend above a creek,
And minnows play at hide-and-seek;
Where buttercups and blue-eyed-grass
Carpet wide meadows, mass on mass.
Pale little feet, now prison-bound,
Your soles can never touch the ground
Till patient skills of earnest men
Unite to make you whole again.

— GRACE S. DOUGLAS

## What Money Buys

Money may buy the husk of things but not the kernel. It brings you food but not the appetite, medicine but not health, acquaintances but not friends, servants but not faithfulness, days of joy but not peace or happiness. — HENRIK IBSEN

## *Student Nurses*

# Malaria

GERMAINE FORTIER

MR. BROWN was admitted to men's medical floor on Monday at 6:00 p.m. He appeared quite ill, so was put to bed at once. While giving admission care, it was noted that he was quite flushed, his skin dry and hot. His only complaint was general malaise. He had been well and at work that day until about 3:00 p.m., when he suddenly felt sick and took a chill.

On admission his temperature was 102°, pulse 100, respirations 22. The provisional diagnosis was bronchopneumonia. Aspirin gr. 15 with soda bicarbonate was ordered every four hours.

When his history was taken, we learned that Mr. Brown had been a member of the Canadian Army in Korea. He had returned to Canada about five months previously and since had been employed as an insurance salesman. He is 35 years of age and has always enjoyed good health, having had only the childhood diseases.

The present symptoms were similar to those that he had had 15 days before. After a few days of care in bed his condition had improved and he was able to be up, apparently cured. Now, however, the symptoms recurred with increased severity and Mr. Brown was hospitalized.

Approximately 12 hours after the chill had occurred, Mr. Brown's temperature returned to normal and he felt better. Penicillin therapy was begun, together with the aspirin, and his condition seemed to improve.

About 3:00 p.m. on the third day Mr. Brown again appeared to be taking a chill. External heat was applied in the form of hot water bottles and extra blankets. The chill became more intense and the doctor was notified. A blood smear was ordered and done.

Mr. Brown now complained of severe headache, pain in his back, and general malaise. He obtained very little relief from the mild analgesic medication. He was placed in Fowler's position to relieve respirations which had become rapid and difficult — probably due to the effect of the chill. His temperature rose to 103°. Demerol 50 mg. was given intramuscularly for pain and gave relief. He was perspiring profusely but seemed to be resting somewhat better. At 8:00 p.m. that evening his temperature dropped to 98°.

The blood smear taken during the chill showed malarial parasites present. Malaria is an acute infectious disease caused by a protozoa which resembles a leukocyte. Their transmission is by way of an intermediate host — the Anopheles mosquito. Each malarial parasite goes through a productive phase within the red blood cells. At the end of maturation the red blood cell is ruptured and the small parasites are freed into the blood stream. At this time the chill and symptomatic reactions occur. The parasites are of three kinds — the tertian parasite whose life cycle requires about 48 hours with the chill occurring on alternate days; the quartan whose cycle takes 72 hours; and the estivo-autumnal so named because the malaria it causes is worse in summer and fall. The incubation period of malaria may be from a few weeks to several months.

The organism in Mr. Brown's case was the tertian parasite because his chill recurred after 48 hours. As soon as the diagnosis was made, quinine gr. 5 q. 3 h. for four doses then gr. 10 t.i.d. was ordered. Quinine, if present in the blood at the time of a chill, will destroy the parasites.

On Sunday, Chloroquine, 4 tablets

---

Miss Fortier is a student nurse at Holy Family Hospital, Prince Albert, Sask.

were given at 8:00 a.m. and 2 tablets at 2:00 p.m., then b.i.d. for the following two days. Chloroquine has a great potency and is effective in suppressing the malaria but does not prevent infection.

Mr. Brown was discharged on Friday, his condition very much improved.

The recurrence rate of malaria is destined to be modified by modern chemotherapy. By using quinine or quinacrine alone, relapses in the case of vivax malaria may be expected three or four years following the initial attack, and in quartan malaria attacks may recur over a period of 15 to 20 years.

Complications attending malaria are anemia, enlargement of the spleen, and cachexia. Treatment is as for malaria accompanied by iron therapy, transfusions, and suitable measures.

# Book Reviews

**Nurse and Patient** — an Ethical Consideration of Human Relations, by Evelyn C. Pearce, with a foreword by Lord Webb-Johnson. 184 pages. British Book Service (Canada) Ltd., 1068 Broadview Ave., Toronto 6. 1953. Price $2.50.

This little book, simply written, is well described as "an ethical consideration of human relations." In it are discussed "the dignity of the human person, the respect and consideration due him, the help he needs in a variety of circumstances, some factors contributing to health breakdown, reactions in illness and recovery processes."

The book is divided into three parts. In the first entitled The Patient, the reader is helped to understand the various factors in health breakdown, the feelings and hidden fears of the sick person, the significance of different reactions to pain, and the management of recovery processes. The second part is devoted to the nurse herself and discusses her reasons for choosing this particular vocation, the human qualities needed, the influence of the nurse, the necessary adjustments and responsibilities, and some of the emotional problems the nurse will encounter.

In the last section, entitled Patients and Nurses are People, Miss Pearce reminds us of the need to respect the dignity of man — including the respect due to children. She quotes from the Universal Declaration of Human Rights to emphasize particular areas in which the nurse has the responsibility and privilege of safeguarding these rights for her patients.

To prevent the human art of nursing being outweighed by the skills of its science, we need frequent recourse to books of this type. Any nurse reading it could hardly fail to gain in sensitivity, and be more effective in her dealings with people.

**Pharmacology and Therapeutics,** by Charles Solomon, M.D., F.A.C.P., with the collaboration of Elizabeth S. Gill, B.S., R.N. 656 pages. J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 6th Ed. 1952. Price $4.50.

This sixth edition of a well known text is noteworthy for its inclusiveness, its new format, and the number of illustrations. It is divided into nine units, the first being a very full introduction and the principles of solutions and dosage. This is followed by a comprehensive list of questions and problems to be solved. The other units are divided according to the action of the drugs and each is followed by questions of the situational type which correlate the material learned with an actual clinical situation.

The new drugs that have met wide acceptance have been given prominent place and there is a section on non-medicinal therapeutics. This latter is largely concerned with physical therapy, with brief references to psychotherapy and dietotherapy.

Though the book is already long, it would seem that in some areas more detail and more precise instructions would be helpful — for instance, the intramuscular injection. Also there might not be complete agreement with the stated Order of Immunization in Children on page 509.

As a textbook for students and a reference for teachers this book is still among the best. The division of the page into two columns makes for easy reading; the chapter

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headings are prominent and descriptive; and the alphabetical index of commonly used drugs and their dosage facilitates very quick reference.

**Psychology, The Nurse and the Patient,** by Doris M. Odlum, M.A., M.R.C.S., L.R.C.P. 114 pages. Published by *Nursing Mirror,* Dorset House, Stamford St., London, S.E.1, Eng. 1952. Price 7/6 (postage 5d.)

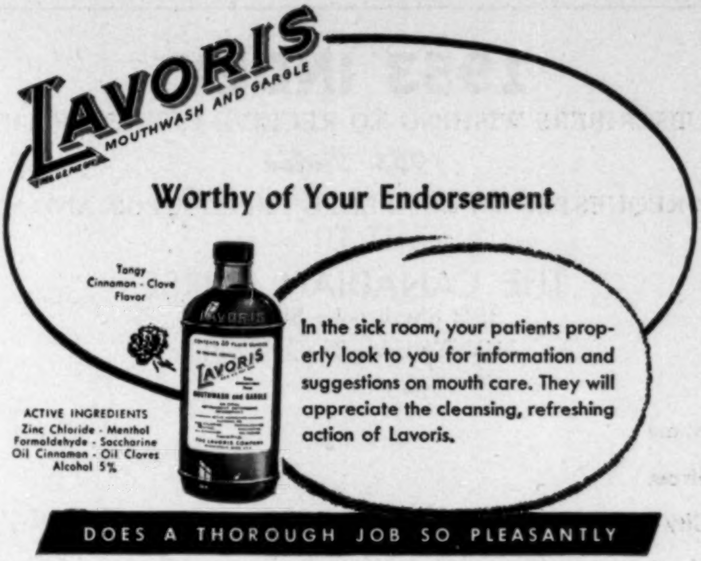
*Reviewed by Lara Thordarson, Metropolitan Health Committee, Vancouver.*

The author, in the foreword to this book, says she hopes "it will be of practical help and guidance to nurses in dealing with their patients as people rather than as animated diseases." I think she has achieved her aim. Students who are beginning the study of nursing will find it a good introduction. It is easy to read and is written in such a way that a student unfamiliar with technical terms does not become bogged down. The writer reviews practical knowledge of psychology and suggests how the nurse may use this knowledge to become a happier, more efficient and understanding person.

This book consists of 14 short chapters. In the first chapter the author says nurses need to know psychology. "If they are going to understand the people they are dealing with it is necessary to have some idea of the way in which the human mind works, of the manner in which folk feel and think and are likely to behave."

The chapters which follow attempt to make clear to the nurse some of the reasons for the behavior of patients. The author reviews the present knowledge on inborn mental factors, presenting William McDougall's theories on instincts, with a very short discussion of Galen's, Kretchmer's and Jung's description of temperament. Development of character and personality is described and the importance of human relationships to healthy personality development is noted. In Chapter 6 the way in which we deal with emotion in our ordinary life through mental mechanisms is outlined. Chapter 8 describes patients and divides them into two groups called "tough," to which 60-70 per cent belong, and the "tender" comprising 30-40 per cent. The "tender" group is said to consist of the anxiety prone, obsessional, histrionic, inadequate.

The author then proceeds to give practical points on helping a patient to adjust to hospital life. The chapter on the nursing of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children brings out many good suggestions as to how parents and nurses can help a child to cope with his hospital experience in such a way that he will not be harmed by the separation from the parent. She states that "in the child's best interests frequent parental visiting is now accepted as essential by all those who understand anything of child psychology." In Chapter 14 she discusses incentives which lead people to take up nursing and something of hospital life.

In the final sentence the author states her reason for writing this book in these words: "My object was rather to present what may be a new point of view to many nurses and to arouse their interest in that most important aspect of nursing — the human approach to the patient." I believe she has succeeded in arousing interest but I would have preferred more discussion, especially on the development of the human personality even though the book is primarily for students beginning the study of nursing.

**Diabetic Manual for the Doctor and Patient,** by Elliott P. Joslin, M.D., Sc.D. 315 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 9th Ed. 1953. Price $3.30.

*Reviewed by Fanny Munroe, former Supt. of Nurses, Royal Victoria Hospital, Montreal.*

This book might well be a manual for everyone. It contains the answers to any question that a nurse might be asked regarding diabetes or that might arise in a nurse's mind. In addition it contains advice on how to avoid diabetes which, if followed, would be invaluable to the general public.

In his optimistic introduction Dr. Joslin states that improvements in methods of treating diabetes are more likely to occur than ever before, owing to the improvement in research; that there are at least three times as many diabetics alive as formerly and probably ten times as many are working and regarded eligible for insurance.

Constantly throughout the book he stresses the danger of overeating and overweight, especially in relation to diabetes. The tendency toward diabetes is hereditary and those overweight after 40 years of age are more apt to contract the disease.

There are chapters dealing with all things related to diabetes, good illustrations of how to administer insulin, food tables for diabetes, food for non-diabetics, diabetic costs, marriage, diabetic children, laboratory tests, employment and insurance for diabetics.

Throughout the book, too, the need for

# 1953 INDEX

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intelligent cooperation is emphasized. Those who follow treatment most carefully live the most comfortable and useful lives. The length of life depends on common sense. Rest is essential and fatigue to be avoided.

The chapter on Prevention of Diabetes also stresses the avoidance of getting fat — diabetics in middle life are proverbially overweight before the disease begins. Exercise, including household activities, is urged. Gallstones are discussed as they are twice as common among diabetics over 25 years of age as among non-diabetics of the same age. Gallstones, the book states, often precede diabetes and may precipitate it by direct extension of infection to the head of the pancreas.

The book is interesting, easy to read, easy to understand, and you can find in it information you may want.

*(Book Reviews concluded on page 152)*

## First Annual Oration

"WAY DOWN UNDER" an event recently took place of great significance to the nursing world:

The New South Wales College of Nursing in Australia conducted its first annual oration and invited from New Zealand a graduate of the University of Toronto School of Nursing to give the oration. The nurse so honored was Miss M. I. Lambie, C.B.E., who took the post-graduate course in public health nursing in Toronto in 1925. On the platform for this history-making occasion were many distinguished persons showing their interest, not only in the nursing profession, but in the development of Australia's oldest university.

Miss Lambie's distinguished career includes being director of the Division of Nursing, New Zealand Board of Health from 1931 until her retirement in 1950; she was first vice-president of the I.C.N. from 1947 until 1953; president of the F.N.I.F. from 1946 to 1949; chairman of the Expert Nursing Committee of WHO in 1950 and is still a member of the panel of nursing advisers to WHO.

The subject of Miss Lambie's address was "The Changing Scene in Health Work Throughout the World" — a comprehensive and masterly résumé of the reasons behind necessary changes in our patterns of nurse education. She pointed out, too, further

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modifications that will have to be made if nursing services are to fill the changing needs of society today. For example, Miss Lambie cited the work of WHO, showing that preventive measures, home education, and proper treatment had not only reduced the need for hospital beds, but also had significantly raised the productive capacity of the people.

". . . The physician who becomes more and more involved in specialized work delegates to the nurse certain tasks which were formerly his; this is true also of the public health officer. The nurse assumes a coordinating role; through the direct contact with the patient she helps him to benefit from all the resources available to him in the public health team. In addition she supervises the work of auxiliary personnel and trains student nurses. Therefore, she must possess besides her professional training a maturity of mind which will enable her to analyze the type of care which a patient requires, to seek continuous growth and development, and to instruct others — the patient and his family as well as auxiliary personnel . . . The principle which has evolved is that nurses must be trained in such a way that they can teach not only the student nurse whom they supervise, but also the patient whom they care for whether he is in the hospital or the home — in short, to *work with* the patient rather than *do for* the patient."

Miss Lambie goes on to describe the various patterns of education being evolved in different countries to meet the changing needs. In her reference to university schools of nursing, the speaker paid a well merited tribute to two outstanding Canadian nurses.

*Miss Lambie giving the Oration.*

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Some years ago a Rockefeller Foundation Report pointed out how far-reaching the personality of those in charge of these courses was, because of their wide influence. In fact the people in charge were far more important than the buildings which housed such schools, this point being illustrated by one or two outstanding examples, such as the Toronto University School of Nursing housed in a crowded old wooden house; but with women of the calibre of Miss Kathleen Russell and Miss Florence Emory in charge. The influence of this school has been world-wide and there have been other schools which have had the same influence due to outstanding teachers.

## Institute in Nursing Education

A two-day institute in nursing education, sponsored by the Regina Grey Nuns' school of nursing, was held in the nurses' residence November 16 and 17, 1953. The first day's program was chaired by Mrs. J. McCormack. Sister I. Papineau, superior and administrator of the hospital, welcomed the group and expressed satisfaction that such an opportunity was being given to the graduate nursing staff of the hospital. The following topics were presented:

The Individual and Group Action, Mrs. J. J. Street; Motivations in Nursing, Father W. Wadey; Public Relations and the Nurse, Mr. P. S. Deis.

On November 17, Miss D. Martin acted as chairman. The program included: Teamwork in Nursing and Medical Services, a panel discussion by Dr. O. E. Laxdal, Miss S. Simpson, and Miss M. Marvin; The Nurse's Place in Society, Sister Marie Cecile; Efficient Nursing Care through Nursing Education, Miss A. Conway.

A group discussion was organized under the leadership of Sister A. Levasseur and two important items concerning simplification of techniques were studied with great enthusiasm:

1. The *omission of morning temperatures* for all patients except for those specified in the nursing orders. The temperatures would then be taken by the day staff. This was unanimously accepted.

2. A *new form to be added to the patient's*

*medical chart* and to be used when the daily hygienic routine care is to be charted: this proposed chart should eliminate unnecessary writing for the nurse. Following a very active discussion it was decided that both hospitals in Regina would experiment with the form for a few patients during a period of a week. A report would then be presented to the educational director and final decision on the matter will be taken at a later date following another discussion period.

## Institute in Nova Scotia

The School of Nursing, Dalhousie University, Halifax, is holding a three-day institute on *Nursing Aspects in the Care of the Child* on ***March 10, 11, 12,*** in the Arts and Administration Building, Studley Campus. There will be a registration fee of $1.00. Members may procure their luncheon tickets at registration on the first day. This will be approximately $2.50.

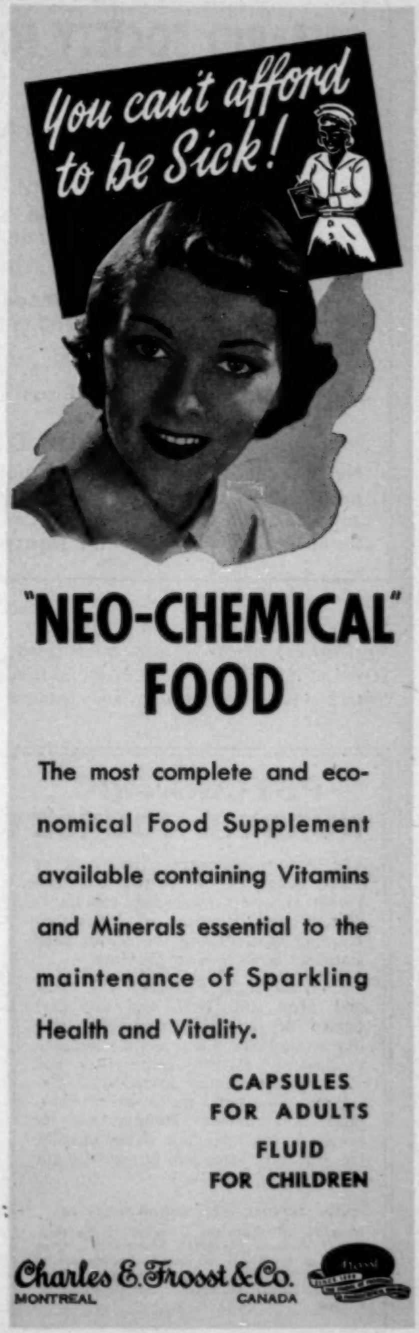
The conference leader at this year's institute will be a member of the staff of the Hospital for Sick Children, Toronto. This will be a splendid opportunity to hear about some of the outstanding work that this world-famous hospital is doing. The guest speaker will be ably supported by Dr. G. B. Wiswell and the staff of the Pediatric Department of the university.

Emphasis will be on nursing aspects in the care of the well and sick child. Discussion of child health centres, films and other visual aid material will be utilized. The program is designed for public health nurses, institutional and private duty nurses caring for children.

## Ontario

The following are staff changes in the Ontario Public Health Nursing Service:

**Appointments** — *Alice Klugman* (Toronto Western Hosp.; University of Western Ontario certificate course; University of Toronto advanced course in administration and supervision) as senior nurse, Wellington County health unit; *Florence (Sparling) Graham-Smith* (Toronto Gen. Hosp. and University of Toronto general course) and *June McKay* (Metropolitan Hosp., Windsor, and U. of T. gen. course) to Kent Co. health unit; *Mary (McVicker) Pippy* (Hôtel Dieu Hosp. and U. of T. gen.



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course) to Kingston Dept. of Health; *Dorothy (Baxter) Rowat* (McMaster University School of Nursing and public health nursing course) to Northumberland and Durham health unit; *Muriel Stewart* (U. of T. degree course) to York Co. health unit; *Nancy Taylor* (T.G.H. and U.W.O. cert. course) to Lambton health unit; *Lorna Warman* (Toronto East Gen. Hosp. and U. of T. gen. course) to Timiskaming health unit.

**PSYCHIATRIC NURSING COURSE**

The Allan Memorial Institute of Psychiatry of the Royal Victoria Hospital offers six-month courses in Theory and Practice in ***Psychiatric Nursing to Graduate Nurses*** in good standing in their own province.

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*For further information write to:*

**Miss H. M. Lamont, Director of Nursing, Royal Victoria Hospital, Montreal 2, Que. or Miss Kathleen Marshall, Supervisor of Nurses, Allan Memorial Institute of Psychiatry, Royal Victoria Hospital, Montreal 2, Que.**

**Resignations** — *Florida Dupuis* as supervisor, Prescott and Russell health unit; *Helen Anderson* from Strathroy board of health; *Thérèse Kelly* from Wellington Co. health unit; *Barbara Stuart* from Guelph board of health.

## Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

**Appointments** — Calgary: *Mrs. Madeleine Sharlow* (Hôtel Dieu, Cornwall). Hamilton: *Joan E. Langford* (St. Joseph's Hosp., Hamilton). Lachine, Que.: *Barbara Connery* (Montreal Gen. Hosp.). Montreal: *Dorothy Abramson* (Guelph Gen. Hosp.), *Betty Gardner* (Queen Elizabeth Hosp., Montreal), *Norma L. Holmes, Dorothy Lennon, Evelyn Stubbs* (all M.G.H.), *Jocelyne Ranger* (Royal Victoria Hosp.,

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Montreal). Regina: *Mrs. B. (Shulte) Osiveny* (Grey Nuns' Hosp., Regina). St. John's: *Nora Fox* (Halifax Infirmary). Saskatoon: *Gerda M. Schuman* (Saskatoon City Hosp.). Toronto: *Mrs. Elizabeth Ashton* (Women's College Hosp., Toronto), *Mrs. Elizabeth J. McCready* (University of Toronto School of Nursing). York Township: *Elizabeth A. Allen* (Toronto Western Hosp.). Weston: *Mrs. Joan Terrapon* (Guy's Hosp., London, Eng.).

**Transfers** — *Ardonna Johnston* from Cornwall to Windsor, Ont.; *Olive Lowten* from Montreal to Ste. Anne de Bellevue as nurse in charge; *Rosalie Proulx* from Ste. Anne de Bellevue to Montreal; *Shirley Smith* from Calgary to Montreal; *Arka Tanaka* from Toronto to Hamilton.

# News Notes

## ALBERTA

### CALGARY

Twenty-five members attended the annual meeting of District 3 held at the Colonel Belcher Hospital. A letter was read from L. Kremer giving a summary of the work done in Civil Defence Planning in Alberta. C. Perkins, assistant editor of *The Canadian Nurse,* was guest speaker, outlining the detailed work and procedure involved in compiling the magazine.

Included in the annual report was mention of the following: The short talk on some of the aspects of medical social service given by M. Bartsch of the Colonel Belcher staff; the demonstration and talk on ballet dancing by Madame Valda; reports of delegates to the A.A.R.N. convention; the success of the refresher course sponsored by the private duty group as well as the monthly meetings of the instructors' group; the course held in Calgary, "Helping the Nurse Develop her Potentialities through Guidance."

### *Holy Cross Hospital*

At a recent meeting of the alumnae association, Mona Sparrow was elected president for the eighth consecutive year. Other officers are: Vice-presidents, E. McLean, J. Cummins; recording and corresponding secretaries, Mmes J. C. McCuaig, E. A. Sullivan, respectively; treasurer, Mrs. B. A. Elleker. The following will also serve in various capacities: A. Griffiths, Mmes A. Benner, K. G. Calvert, W. Castleman, R. Jackson, J. D. Willocks, T. E. Jacques, K.

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**Director of Nurses,**
**1601 Spring Garden Street**
**Philadelphia 30, Penna.**

E. Baker, D. D. Batdorf, A. D. McAlpine, J. L. Barlass.

Sr. Superior Letellier, honorary president, and Sr. Leclerc, honorary vice-president, were guests of honor. Sr. Superior was presented with a pair of silver candelabra by the president, on behalf of the alumnae. Following refreshments, the student nurses presented a humorous skit.

### HANNA

The November meeting of District 5 was attended by 11 members. It was decided that Mmes White, Woods and Pelletier be sent as delegates to Banff for the C.N.A. Biennial Convention. Miss McKinnon of the Program Committee read about "Disaster Nursing."

### CLARESHOLM

The summer effort of Claresholm Branch was the sending of 90 lb. of uniforms and clothing to Miss Sandell in Korea. Also, at her request, the branch sent a half-dozen scrub-up brushes along with gum and candy. Miss C. W. Perkins, field representative for *The Canadian Nurse,* gave a most informative talk at the September meeting.

### VULCAN

At a regular meeting of the Vulcan Chapter, it was decided to finance two delegates to the C.N.A. Biennial Meeting to be held in Banff this June.

### LAMONT

### *Archer Memorial Hospital*

The following amendment to the Constitution was made at the annual alumnae meeting: "The name of the Association shall be 'The Alumnae Association of The Archer Memorial Hospital of Lamont School of Nurses.'" A motion was passed to send a gift of money to aid Ada Sandell in her missionary work in Korea. After the chicken supper that followed the meeting, there was a welcoming address by the former president, Mrs. A. B. Cowan, and a delightful talk by L. M. Young, superintendent of nurses. Dr. M. A. R. Young, hospital superintendent, and Mrs. Young were present. Dr. Young spoke on "The Nursing Shortage" and "The Origin and Meaning of Alma Mater." Travel films were shown through courtesy of Imperial Oil Ltd.

Officers elected are: President, Mrs. A. Strong; vice-presidents, Mrs. W. Motycka, J. Graham; secretary-treasurer, Mrs. B. I. Love.

Alumnae meetings will be held the third Monday of every second month, as follows: *March,* home of Mrs. G. Harrold, Lamont; *May,* graduation, Lamont; *September,* nurses' residence, Lamont; *November* (first Friday), annual meeting, Edmonton.

## BRITISH COLUMBIA

### VANCOUVER ISLAND DISTRICT

The district officers for the coming months are as follows: President, Mrs. V. Tams, Courtenay; vice-president, Mrs. J. Field, Nanaimo; secretary-treasurer, Mrs. O. Bell, Courtenay. Councillors: D. Priestley, Nanaimo; Mmes Bosward (Victoria) and Tams. Chapter presidents: Alberni, Mrs. M. Spencer; Cowichan, Mrs. W. MacPherson; Ladysmith, Mrs. A. Quayle; Nanaimo, Mrs. J. Best; Victoria, Miss Harris; Plateau, Mrs. R. Canlan. The representative to *The Canadian Nurse* is Mrs. B. Bennett.

A regular district meeting was held recently at the Royal Jubilee Hospital, Victoria, with full representation. Alice Wright, R.N.A.B.C. executive secretary, was guest speaker and gave an interesting account of her trip to Brazil and the I.C.N. Congress. Color slides she took on the way to and from Brazil were much enjoyed. Members of the hostess chapter served refreshments.

### Ladysmith

A regular monthly meeting of Ladysmith District was held in November with 18 members present. Mrs. A. Quayle presided. The Civil Defence lectures and demonstrations of equipment were successfully completed. It was reported that the members were actively aiding the community plans for the new hospital. A hearty vote of thanks was extended to the past president, Mrs. M. Neville, and the officers for a successful year. A film on prenatal and post-natal care was shown by H. Fulmore, district public health nurse, depicting the work in the public health field.

The officers for 1954 are: President, Mrs. A. Quayle; secretary, Mrs. R. Berto; treasurer, Mrs. J. Bredenberg; social convener, Mrs. E. Gregson; membership convener, Mrs. Neville.

### Prince George

At the short business meeting of the Fort George Chapter held before the enjoyable Christmas party at the nurses' residence, Mrs. L. Stewart agreed to act as correspondent for the Institutional Nursing Committee. Plans were made for the donation of the annual Christmas hamper to a needy family and for the arrangement of talks on subjects of interest to nurses by doctors and nutritionists.

### Vernon

The monthly meeting of the Vernon Chapter was held in the nurses' home with the president, J. Sutcliffe, in the chair. Several points for discussion arose, among them a rummage sale. A member suggested that a professional group should raise money from their own resources, and leave this means of support to church and philanthropic organizations. It was agreed that she had made a good point.

The highlight of the meeting was the guest speaker, Miss Hurd. Associated with the United Church, she taught in mission schools in Japan for many years. She spoke about her trip to Japan last summer and

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compared pre- and post-war conditions.

### BURNABY

Christine MacCullie now holds the position of director of nurses at the General Hospital.

## MANITOBA

### BRANDON

The Association of Graduate Nurses met recently at the Hospital for Mental Diseases, with the president, Mrs. E. Hannah, in the chair and 45 members present. Mrs. L. Moir gave the report of the secretary and treasurer, and a letter from the scholarship recipient for 1953 was read. The president made an appeal for the Hitschmanova Fund and Mrs. G. Hannah stated that 128 ladies from 23 groups in the Local Council of Women received and packed clothing. A. Bennett reported that the cookbooks had been sold and the fund closed. Mrs. J. Brereton moved a vote of thanks to Miss Bennett. Mrs. S. J. S. Pierce recounted briefly the launching of this project a few years ago. M. Jackson stated that two students were planning to attend the C.N.A. Convention at Banff in June, this being made possible by the successful Frosty Fall Frolic.

Following the business meeting, P. Beecher's group took charge and Rev. J. T. Horricks spoke on "The Meaning of Christmas." C. Hannah thanked the speaker. Mrs. M. White conducted the carol singing with R. Shanks as accompanist. Winners of the contests were Mmes Durnin and S. Lewis, after which P. Long helped Santa Claus distribute gifts. A buffet lunch closed the evening.

### WINNIPEG

### *General Hospital*

The alumnae association held their annual meeting in November when reports were read and the new officers for the ensuing year installed. Bertha Pullen, who has resigned her position as superintendent of nurses, was presented with a gift of jewellery in appreciation of her support to the alumnae.

Following a short business meeting in December, a Christmas Carol service was held. Those attending brought gifts for the shut-ins. Rev. M. McLuban read the story "The Other Wise Man."

### *Misericordia Hospital*

The alumnae association Christmas party was attended by 150 nurses including eight senior students. Twelve out-of-town members were also present. Mary Lang was master of ceremonies while Mrs. D. Cutts was director of the entertainment committee. Original songs, skits and dances were presented, followed by a buffet supper. Each member brought a gift and Santa Claus was portrayed by F. Menzies.

## ONTARIO

### District 2

**Brantford**

Katherine M. Bowen recently opened the new $65,000 home that is named after her at the Brant Sanatorium. Miss Bowen was a pioneer in tuberculosis work which she entered after the death of her fiancé, a Royal Navy surgeon. She was superintendent at the Brant San from 1916 to 1938, in which year the Ontario Government ruled that superintendents of sanatoriums must be doctors. Miss Bowen then became superintendent of nurses until 1946.

It was due to her "education" work that the 20-bed san in those early years became a success and T.B. patients learned the value of treatment. Some of her patients of 20 years ago were at the opening and telegrams of good wishes came from others in the U.S.A., Ontario, and Saskatchewan.

Miss Bowen was born in England, later obtaining her nursing training at Weston, Ont., and Bellevue and Fordham hospitals in New York City.

### District 5

**Toronto**

*St. Michael's Hospital*

At an alumnae meeting, the guest speaker was Sr. Mary Kathleen who gave an interesting and enlightening talk on the school of nursing and the origin of the Sisters of St. Joseph. N. Devenish gave an informative talk on the progress of the R.N.A.O. since its formation.

Sr. Mary Antonia (Josephine LaPresti), of the Maryknoll Community, has been assigned to active mission work in the Bolivia-Peru region. Sr. Carmilla is superior of Our Lady of Mercy Hospital. Sr. Mary Lois is now director of nursing service at St. Joseph's Hospital, Barrhead, Alta. Mary Brown is on the staff of the Red Cross Clinic, Toronto. M. Nealon is doing public health nursing in Alliston.

*University of Toronto School of Nursing*

The University of Toronto School of Nursing alumnae held open house in November at the new school, 50 St. George St. The alumnae president, Gwladwen Jones, with Prof. Nettie D. Fidler, director of the school, Prof. F. H. M. Emory, associate director, and Eileen Cryderman, alumnae past president, received the guests. The sum of $20,000, contributed by the association, will be used for the furnishing of assembly hall, staff and student sitting rooms, and lunchrooms in the new building.

*Women's College Hospital*

Miss Clinton thanks her committee and the alumnae members and friends who help-

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- Course begins ***September, January, 1954,*** and ***June.*** Enrolment limited to a maximum of six students.

*For further information write to:*

**Supt. of Nurses,**
**General Hospital,**
**Winnipeg, Man.**

ed to make the dance and draw a success. April 23 is the date set for the graduation dinner for the 1954 class. Edith Hillary is doing private nursing in Grand Rapids, Mich. N/S Gaynoll Davis is matron at Trenton Air Force Base.

### DISTRICT 7

#### *Brockville General Hospital*

The alumnae association had a very busy and successful fall season. In November the annual bazaar took place, the proceeds purchasing a 16 mm.-movie projector for the school of nursing, to be used for educational purposes. Presentation of the projector was made to Gertrude E. Gibson, director of nursing education, at which time a movie was shown of the Canadian Pacific Airlines.

In the photo may be seen (*left to right*): MISS GIBSON, MRS. H. W. GREENE, alumnae president, and VERA J. PRESTON, director of the school.

### DISTRICT 8

#### OTTAWA

Evelyn Horsey was elected chairman of District 8 at the recent annual meeting, over which past chairman, M. Nephew, presided. Associated in office with Miss Horsey for the coming months are: Vice-chairmen, V. Adair, E. Feasby; secretary, R. MacIsaac; treasurer, F. Fournier. Chapter chairmen: Cornwall, Sr. M. Mooney; Pembroke, E. Sheppard; Ottawa area, A. Macleod. Reports of the secretary, treasurer, nominating committee, and membership convener were heard. Agnes Macleod gave an address on the highlights of the I.C.N. Congress in Brazil, while Mildred Walker gave a summary of the C.N.A. Structure Study.

#### *Civic Hospital*

At a regular alumnae meeting $25 was voted towards the Community Chest Drive and $10 for the purchase of a poppy wreath to be laid at the Cenotaph. At a later meeting, chaired by the vice-president, D. Ainger, the highlight was a tour through the new East Lawn Pavilion and a demonstration of the latest model of the iron lung.

The alumnae tea, sale of home cooking and candy proved a great success when the guests were received by V. Adair, president, and Miss Ainger.

The 1953 bursary loan was awarded to C. Arnold and S. Gibbons who are taking the teaching and supervision course at McGill.

L. McLellan is in charge of the nursing assistants, O.C.H. J. Perrin is clinical supervisor, 1-E, while M. Bennett, returned from Vancouver, is assistant head nurse, 5-E. A. Lyons is doing private nursing, Fredericton. F. (Fletcher) Vance is in charge of the Blood and Bone Bank, Victoria Hospital, London. T. (Hawkshaw) Carter is O.R. supervisor, Jefferson Hospital, Va. B. (Sharman) Oatway is on the staff of the new maternity wing, St. Francis General Hospital, Smiths Falls. E. Tingley and P. Legault are at Kootenay Lake General Hospital, Nelson, B.C. J. Lee is on staff at Sunnybrook Hospital, Toronto. I. McCauley and A. Gadd are serving with the Elizabeth M. Crowe Hospital, Erickson, Man. G. (Brady) Watt has resigned as nurse counsellor with the Dept. of National Health and Welfare to accept the post of industrial nurse with Imperial Oil Ltd., Sarnia.

A. Young is completing her degree course at McGill in teaching and supervision while E. Johnston is at Western University taking that same work. L. Fischl is at Ottawa University, enrolled in the public health course. M. Ernst and M. Bindel took a course in polio care last summer at Jefferson Davis Hospital, Houston, Texas. They spent a month at Warm Springs prior to returning to Mexico. L. Schiemann is taking a physiotherapy course at the American-English Hospital, Mexico City.

## PRINCE EDWARD ISLAND

Mrs. L. Clapp and R. Poirier of the Provincial Sanatorium staff, Sr. M. Hermina, Charlottetown Hospital, Mrs. L. Kitchen, Falconwood Hospital, and Norma Craig, Prince County Hospital, Summerside, were among the group of 26 nurses taking a two-week workshop on ward management and clinical teaching at Dalhousie University School of Nursing, Halifax.

### MONTAGUE

V. Darrach, president of the A.N.P.E.I., and the secretary-registrar, M. Archibald, attended a get-together of the registered nurses at the home of Mrs. W. Beer. Plans were discussed for the annual meeting of the A.N.P.E.I. The provincial association has accepted an invitation to hold a general meeting at Montague. Interest was shown in forming a local chapter and this will be discussed in the future. Miss Archibald spoke on the C.N.A. Structure Study.

### SUMMERSIDE

At a regular meeting of the Summerside District, president N. Craig and 20 other members attended. M. Archibald, A.N.P.E.I.

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secretary-registrar, gave a very informative and interesting talk on "The Structure Study of the C.N.A."

H. Schurman, superintendent of the Prince Co. Hospital, has resigned to accept the superintendency of Carleton Memorial Hospital, Woodstock, N.B. Prior to her departure, the staff nurses gave a dinner party in her honor and presented her with a gift.

## QUEBEC

### MONTREAL

### *Children's Memorial Hospital*

Recent additions to the staff include: as teaching supervisors, N. Pearson, M. Pinkerton; to out-patient dept., B. Ralph, R. Thomson, H. O'Shea; to operating room, T. Molloy, J. Berry, P. McKenney, I. Jaroszweskie; as staff assistants, L. Burquez, J. Murphy, N. Brown, K. MacNeill, N. Burns, D. Stairs, M. Reiffenstein, L. Bennett; as ward secretaries, D. Rosenberg, J. Ellemo; to general duty, Ward L, M. L. Gates, P. Sandell.

The following have resigned: T. Potter, as medical supervisor; M. Cochrane, as infant supervisor, to return to the West Coast; J. Forgrave, head nurse, Ward D, to rejoin the Navy; M. McKenney, head nurse, Ward L, to join the R.C.N.V.R.

### *Reddy Memorial Hospital*

At a regular meeting of the alumnae association, Mrs. R. Wolfson presided when a list of officers for the forthcoming election was drawn up. Bingo and refreshments were later enjoyed.

### *Royal Victoria Hospital*

In October, 1952, Fanny Munroe was appointed chairman of a committee to organize alumnae chapters of the R.V.H. across Canada. At that time Vancouver, Hamilton, Moncton and Halifax chapters had been active for some time. A graduate in each city, where there seemed to be a sufficient number of them to make a chapter possible, was written, proposing that a chapter be formed. The purpose was to keep in touch with the alumnae association. No fees were necessary and any R.V.H. graduate, whether an alumnae member or not, was to be asked to join. It was suggested that a social gathering be held once a year or oftener as the chapter wished and that names and addresses of officers and those attending be forwarded to the alumnae secretary.

The response was enthusiastic and at present there are chapters in Halifax, Pictou County, Charlottetown, Moncton, Saint John, Kingston, Ottawa, Toronto, Hamilton, Winnipeg, Calgary, Edmonton, Vancouver, and Victoria. Every province except Newfoundland and Saskatchewan is represented and the alumnae would gladly assist in any way even a small group in any town in these provinces interested in forming a chapter.

A meeting of the Victoria Chapter was held recently at the home of Mrs. E. W. (Edsell) Boak when B. Davis was appointed secretary. Pictou Co. Chapter plans a meeting early this year and a chapter has been organized in London, Ont., with Mrs. W. (Parry) Scundrelt as president, E. Manning as secretary.

The annual Christmas tea was held early in December with a good attendance. Special guest was Barbara Whitley.

Maude Dolphin has been recruited by WHO from Canada. For the past few years she has been working at the Vancouver General Hospital as senior administrative instructor of nursing arts. She has gone to Dacca, E. Pakistan, where she joined the WHO team that is assisting in the development of a school of nursing. Miss Dolphin's chief responsibility will be in relation to the teaching and clinical supervision of pediatrics.

Jean C. MacGregor has joined the staff of the General Hospital, Calgary, while D. Reed is going to the Presbyterian Hospital, New York. G. (Simpson) Johnson is now in Los Angeles at the Permanente Medical Center. A recent visitor to the school was Mrs. W. L. (Hamilton) Dawson.

## SASKATCHEWAN

### FORT SAN

Barbara Swanton was the speaker recently at a meeting of the Qu'Appelle Valley Chapter. She was one of 13 girl guides chosen to go to London for the Coronation. Pictures in color illustrating her talk showed glorious sunshine in the midst of an otherwise rainy day. The chapter was very successful in a drive for funds for the Canadian Arthritic and Rheumatism Society.

### SASKATOON

A regular meeting of the Saskatoon Chapter was held at the City Hospital nurses' residence when an interesting talk was given by Mrs. R. Carter.

### *City Hospital*

A "Snowball Flurry" dance was held in November, the convener being M. Bell. The following graciously acted as patrons and patronesses: Mr. and Mrs. J. E. Armstrong, Dr. and Mrs. E. F. Routley, Dr. and Mrs. R. W. Cram. The 1954 -B class conducted a Variety Night with M. Gunderson serving as convener.

New staff members include J. Hill, Mmes H. Lyons and E. Snape.

### *St. Paul's Hospital*

The School of Nursing Christmas concert was a great success. The medical staff made a gift of a radio-record player to the nurses' residence while Sr. Superior presented the nurses with a new electric washing machine and four irons.

M. Cook, nursing arts instructor, is leaving to be married.

**DALHOUSIE UNIVERSITY**

**Courses for Graduate Nurses**

*Term 1954-1955*

The School of Nursing offers one-year Diploma Courses in the following fields:

1. *Public Health Nursing.*
2. *Teaching and Supervision in Schools of Nursing.*

*For further information write to:*

**The Director**
**School of Nursing**
**Dalhousie University**
**Halifax, N.S.**

**GENERAL DUTY NURSES**

**and**

**OPERATING ROOM NURSES**

**300-bed hospital**

- **Well equipped**
- **Good working conditions**
- **Cafeteria**

*Salary:* $207 per month
44-hour week

Apply

**Director of Nursing Services,**
**Metropolitan General Hospital,**
**Windsor, Ontario.**

**When YOU were a Baby**

Your mother probably gave you Steedman's Powders for babyhood upsets. For 100 years, mothers, doctors and nurses have known that Steedman's Powders quickly relieve colic, feverishness and other minor ills. 8 out of 10 druggists recommend Steedman's, too . . . the fastest-selling product of its kind in Canada. Safe, gentle, easy to give.

**STEEDMAN'S POWDERS**

*For Teething Babies*

**TORONTO HOSPITAL FOR TUBERCULOSIS**

**Weston, Ontario**

***Post-Graduate Course in the Treatment, Prevention, and Control of Tuberculosis:***

1. A nine-week certificate course in surgical and medical clinical experience, lectures and demonstrations. Rotation to all departments.
2. An extra month in special departments may be arranged for those nurses preparing for Public Health, Operating Room or Surgical Nursing.

***For further particulars apply to:***

**Director of Nurses, Toronto Hospital, Weston, Ontario**

**School Nursing in the Community Program,** by Marie Swanson, R.N., M.A. 543 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1953. Price $5.00. *Reviewed by Catherine W. Perkins, formerly supervisor of public health nursing, Victoria, B.C.*

"This is a book about school nursing but obviously is not written with school nurses as the single target readership." This telling statement about this book appears in the foreword by Marion W. Sheahan and gives just a glimpse of the broad scope of the material. Though designed especially to answer the questions of public health nurses in schools, the book deals with the responsibilities of all personnel concerned with the well-being of school children. The nurse is given her proper place as an advising, coordinating member of a professional group, and it is in this role that her most valuable contribution is made. Emphasis is constantly placed on the vital importance of the parents and the family physician, theirs being the final decision in matters concerning the health of the child.

The five divisions of the book are clearly described in the table of contents, and cover the community's part; planning the nurse's work; her part in dealing with individual pupils, and in general health supervision; and the nurse working in special situations. Each area is dealt with in detail, especially the descriptions of the nurse's work and her share of group responsibility.

The format is pleasing and the print easy to read. Individual topics are printed in boldface italics so that they stand out, greatly facilitating reference to any one phase of the work. At the end of each chapter is a list of references used. The list of organizations and magazines, though confined to those in the United States, will be of practical help to readers.

School administrators and teachers could use the book to good advantage to clarify their role in ensuring total health for their school population. For students of public health and nurses working in schools, and as a reference for teachers of public health, it would be invaluable.

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No one who has watched the sick can doubt the fact that some feel stimulus from looking at scarlet flowers, exhaustion from looking at deep blue, etc.

— Florence Nightingale

## THE ASSOCIATION OF NURSES OF THE PROVINCE OF QUEBEC

The 1954 Spring Examinations for Provincial Registration will cover two groups of candidates and will be held as follows:

### EXAMINATIONS FOR REGISTRATION — PART II

Graduates desiring to qualify for a licence to practise will write on **April 12, 13, and 14, 1954.** Candidates will not be permitted to write these examinations until they have actually completed their training and hold the diploma of their school. **Applications must be received by March 9, 1954.**

### EXAMINATIONS FOR REGISTRATION — PART I

Students who will have completed their first year will enter the Examinations for Registration, Part I, which will be held on **March 15, 16, 17, and 18, 1954.** (Time to be announced in each school.) **Applications must be received by February 12, 1954.**

*For application forms and all information relating to the examinations, apply to the headquarters of the Association.*

**A. WINONAH LINDSAY, R.N.**
*Secretary-Registrar.*

**Suite 506 — 1538 Sherbrooke St., West, Montreal 25, Que.**

# Positions Vacant

ADVERTISING RATES — *$5.00 for 3 lines or less; $1.00 for each additional line.*
U.S.A. & Foreign — *$7.50 for 3 lines or less; $1.50 for each additional line.*

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**Supt. of Nurses & O.R. Supervisor** for General Hospital, Dauphin, Man. 86-bed hospital with Nurses' Training School. Community of 6,500. Excellent living conditions. Supt. of Nurses must be good organizer & disciplinarian. Salary open for both positions. For further information apply A. J. Schmiedl, Sec.-Mgr.

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**Instructor in Science & Surgical Nursing** for new school taking in one class yearly. Responsible for teaching Chemistry, & Anatomy & Physiology in 1st term & the Surgical portion of an integrated course in Medical-Surgical Nursing in 2nd term. Splendid opportunity to help develop new school being established on sound educational lines. For further information apply Director, School of Nursing, Metropolitan General Hospital, Windsor, Ont.

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**Obstetrical Supervisor** (qualified) for active dept. with staff of rotating head nurses. Apply Director of Nurses, Greater Niagara General Hospital, Niagara Falls, Ont.

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**Asst. Operating Room Supervisor.** Busy unit with adequate graduate staff. Post-graduate experience preferred, previous experience considered. Good personnel policies. For further information apply Director of Nursing, General Hospital, Belleville, Ontario.

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**Obstetrical Supervisor (3-11)** for 30-bed unit & nursery. Post-graduate experience preferred. Good personnel policies. For further information apply Director of Nursing, General Hospital, Belleville, Ont.

---

**Public Health Nurse** for Health Unit for generalized program. Proximity to Toronto permits urban living conditions to be combined with rural-urban work. Excellent transportation arrangements, group insurance & other attractive working conditions. Apply Dr. R. M. King, York County Health Unit, Newmarket, Ont.

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**Registered Nurses** for the Public Health Nursing field by the Saskatchewan Department of Public Health. Provision is made for in-service training & for financial assistance to complete university post-graduate training in Public Health Nursing. For application forms & further information apply Public Service Commission, Legislative Bldgs., Regina, Sask.

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**Registered Nurses** for floor duty in 50-bed modern General Hospital. Apply District Memorial Hospital, Leamington, Ont.

## CENTRAL SUPPLY ROOM SUPERVISOR

for

## Victoria Hospital, London, Ontario

**Applications requested for this position in 700-bed active hospital.**

The Central Supply Room is to be transferred to new area with modern equipment, in the new wing, to be opened in September.

*Good Salary and Personnel Policies.*

Apply

**Director of Nursing, Victoria Hospital, London, Ontario.**

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**Registered Nurses for General Duty** in 600-bed hospital for Tuberculosis. Initial gross salary: $185 per mo. 8-hr. duty, 44-hr. wk. Board & room available. Apply Director of Nursing, Beck Memorial Sanatorium, London, Ont.

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**Registered Nurse** to replace me at E.M.C. Memorial Hospital, Eriksdale, Man. I have been transferred from this pleasant little hospital, just 90 miles from Winnipeg, to Alberta. Please contact Miss E. I. Miller, Supt., for particulars. — A.G.G.

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**Director of Nurses & Principal of School of Nursing** for 117-bed General Hospital. Post-graduate course in administration or equivalent experience required. Salary open. Suite in modern residence. Construction of new 150-bed hospital under way. Apply, giving details of education, qualifications, experience, enclosing recent photo. Administrator, Jeffery Hale's Hospital, Quebec City, Que.

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**Director of Nursing** for 100-bed General Hospital situated on Trans-Canada Highway, 65 miles east of Vancouver, in beautiful Fraser Valley. Additional wing in planning stages. Apply, stating full details of education, post-graduate training, experience, availability & salary expected, Administrator, General Hospital, Chilliwack, B.C.

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**Supt. of Nurses** for 22-bed hospital. Commencing salary: $270 gross. Increments every 6 mos. for 2½ yrs. Living accommodation in separate modern nurses' residence with automatic heating & hot water supply. 1 mo. holiday after 1 yr. service. Statutory holidays & cumulative sick leave. Hospital well equipped, with staff of 4 nurses, 4 aides, combined laboratory & x-ray technician, cook, asst. cook, maid & janitor. No business matters to handle such as bookkeeping, etc. Transportation fare advanced if requested. Apply Mrs. H. E. Ashcroft, Supt. of Nurses, Union Hospital, Hafford, Sask.

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**Supt.** for 125-bed hospital with small Training School. Apply Sec., Board of Trustees, Prince County Hospital, Summerside, P.E.I.

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**Instructor of Nurses** urgently required. Excellent salary & personnel policies. 65 students. Apply Miss B. A. Beattie, Director of Nurses, Public General Hospital, Chatham, Ontario.

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**Nursing Arts Instructor** for School of Nursing. 150 students—450-bed hospital. Apply Director of Nursing, General Hospital, Saint John, N.B.

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**Clinical Instructor (Medical-Surgical).** 155-bed General Hospital. 75-bed addition in near future. Salary: $260 per mo. with complete maintenance. Good personnel policies. 44-hr. wk. Apply Director of Nurses, Chesapeake & Ohio Hospital, Clifton Forge, Virginia.

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**Educational Director** (qualified). 548 beds. Well established affiliation program; to initiate Staff Education Program. Communicable, tuberculosis & chronic diseases. Excellent personnel policies, working conditions, pension plan. Annual vacation with pay, statutory holidays, sick benefit plan. Salary: $253-271. Apply, stating full qualifications, experience, etc., in first letter, Mr. J. McIntyre, Administrator, Municipal Hospitals, Winnipeg, Man.

# WANTED

## CLINICAL INSTRUCTOR FOR PEDIATRICS

*for*

***War Memorial Children's Hospital***

Capacity: 140-150 beds.

Post-graduate course preferred.

Good salary and Personnel Policies.

*Apply:*

**Director of Nursing, Victoria Hospital, London, Ontario.**

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**Teaching Supervisor** for Communicable Diseases Division of 800-bed hospital. Salary: minimum as per S.R.N.A.; maximum depending on qualifications & experience. Automatic increase each 6-mo. period. Proportionate vacation up to 1 mo. after 1 yr. Cumulative sick time; 10 statutory holidays; 44-hr. wk. Apply Supt. of Nurses, General Hospital, Regina, Sask.

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**Nursing Arts Instructor (1) Surgical Clinical Instructor (1).** School of Nursing with 90 students. Duties to commence April 1. Apply Director of Nursing, General Hospital, Oshawa, Ont.

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**Science Instructor, Clinical Teacher & General Duty Nurses** for 500-bed hospital. 40-hr. wk. Good personnel policies. Apply Director of Nursing, St. Joseph's Hospital, Victoria, British Columbia.

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**Matron** for 31-bed hospital by Feb. 1. Salary: $290 less $45 for board & private 3-room suite. Fare from Vancouver refunded after 6 mos. R.N.A.B.C. personnel practices. Interesting literature on this modern company town mailed upon request. Apply, giving full particulars, qualifications, F. N. Wood, Administrator, P.O. Box 640, Ocean Falls, British Columbia.

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**Night Supervisor** for 100-bed hospital. Apply, stating experience, references, etc., Supt., The Cottage Hospital, Pembroke, Ont.

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**Operating Room Supervisor.** 800-bed hospital. 13 theatres. Modern equipment. Salary: minimum as per S.R.N.A., maximum depending on qualifications & experience. Automatic increase each 6-mo. period. Proportionate vacation up to 1 mo. after 1 yr. Cumulative sick time; 10 statutory holidays; 44-hr. wk. Apply Supt. of Nurses, General Hospital, Regina, Sask.

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**Operating Room Supervisor** (special preparation preferred). Also **Dietitian & Night Supervisor** for 100-bed hospital. Salary depends on qualifications & experience. Apply Soldiers' Memorial Hospital, Campbellton, N.B.

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**Operating Room Scrub Nurses.** 800-bed hospital. Salary: minimum as per S.R.N.A., maximum depending on qualifications & experience. Automatic increase each 6-mo. period. Proportionate vacation up to 1 mo. after 1 yr. Cumulative sick time; 10 statutory holidays; 44-hr. wk. Apply Supt. of Nurses, General Hospital, Regina, Sask.

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**Dietitian** (qualified) for Teaching Hospital. Opportunity for advancement. Full maintenance. Fare from Canada for accepted candidate. For full particulars, write, giving qualifications & date available, Matron, King Edward VII Memorial Hospital, Bermuda.

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**Public Health Nurses** for city school health program. Starting salary: $2,791 (1953 rate). Excellent working conditions. Personnel policies on request. Apply Supervisor of School Nursing, Health Dept., City Hall, Calgary, Alta.

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**Registered General Duty Nurses.** 60-bed hospital. 44-hr. wk. 21 days annual holiday. 8 statutory holidays. 2 wks. sick leave. Apply Supt., Public Hospital, Smiths Falls, Ont.

## THE MONTREAL GENERAL HOSPITAL

*The Montreal General Hospital requires:*

(1) ***General Staff Nurses.***
(2) ***Operating Room Nurses.***

An interesting variety of experience is available to **Registered Nurses,** both on the Wards and in the Operating Room.

*For further information apply to:*
**The Director of Nursing, The Montreal General Hospital,**
**60 Dorchester St. East, Montreal 18, Quebec.**

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**Laboratory Technician (1), Registered Nurses (5) — one with O.R. experience.** Also **Grace Maternity Graduates.** Three 8-hr. shifts, alternating weekly. Good personnel policies covering vacation, hospitalization & sick time. Apply Supt., Queens General Hospital, Liverpool, N.S.

---

**General Duty, Operating Room & Maternity Nurses.** Salary: $182.50 for recent graduates. 1 meal, laundry. 8-hr. day, 44-hr. wk. — straight shift. $15 differential evenings — $10 nights. Vacation, sick time, statutory holidays on salary. Semi-annual & annual increments. Financial recognition for yrs. of experience, post-graduate or university study. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

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**Registered Nurses for General Staff Duty** in 114-bed hospital. Beginning salary: $210 per mo. with advancement to $225. Recognition for yrs. of experience. For further information apply Director of Nurses, Union Hospital, Swift Current, Sask.

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**General Duty Registered Nurses (2)** for 30-bed hospital in northwestern Ontario, the heart of a tourists' paradise. Separate nurses' residence, fully modern. Salary: $160 per mo. plus full maintenance. Salaries subject to annual increase. 30 days vacation after 1 yr. service. Successful applicants reimbursed rail fare after 1 yr. Apply, stating age & when available, Supt., District General Hospital, Dryden, Ont.

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**Clinical Supervisors & Instructors: Surgical (2) & Medical (2).** Also **General Staff Nurses.** Personnel policies based on R.N.A.O. recommendations. For full details apply Director of Nursing, General Hospital, Port Arthur, Ont.

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**General Staff Nurses** for 400-bed Medical & Surgical Sanatorium, fully approved. Student affiliation & post-graduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

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**General Duty Nurses.** Gross salary: $200 per mo. with 1 yr. or more of experience; $190 per mo. with less than 1 yr. experience; $20 per mo. bonus for evening or night duty. Annual increment, $10 per mo. 44-hr. wk. 8 statutory holidays. 21 days vacation & 14 days sick leave with pay after 1 yr. employment. Apply Director of Nursing, General Hospital, Oshawa, Ont.

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**General Duty Nurses** — "You will like it here." Placement in the service of your choice in Teaching Hospital. Beginning salary: $240 per mo. for 40-hr. wk. Scheduled increases, payment for overtime, 6-hr. evening duty. $270 per mo. for night duty. Sick leave, 6 holidays, 3 wks. vacation. Residence facilities if desired. Tuition-free courses after 6 mos. service. Opportunities for advancement. Apply Director of Nursing Service, University Hospitals of Cleveland, Cleveland 6, Ohio.

## VICTORIAN ORDER OF NURSES FOR CANADA

*has Staff and Supervisory positions in various parts of Canada.*

***Personnel Practices Provide:***

- Opportunity for promotion.
- Transportation while on duty.
- Vacation with pay.
- Retirement annuity benefits.

*For further information write to:*

**Director in Chief,**
Victorian Order of Nurses for Canada,
193 Sparks Street, Ottawa 4, Ont.

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**General Duty Nurses** for 920-bed General Hospital. Starting salary: $190-210 per mo. plus meals & laundry. Credit for past experience, annual increments. 44-hr. wk., rotating shifts. Statutory holidays, 21 days vacation, cumulative sick leave, hospitalization subsidized, pension plan. For further information apply Supt. of Nursing Service, University of Alberta Hospital, Edmonton, Alta.

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**General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics.** Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

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**General Duty Nurses** for 110-bed hospital in scenic Fraser Valley, 65 miles east of Vancouver on Trans-Canada Highway. Salaries, holidays, etc., in accordance with R.N.A.B.C. personnel practices. Residence accommodation available. Apply Director of Nursing, General Hospital, Chilliwack, B.C.

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**General Duty Nurses** for 200-bed General Hospital in B.C. Interior. Starting salary: $225. Annual increments. Credit for past experience. 28 days annual vacation. Cumulative sick leave. Apply Director of Nursing, Royal Inland Hospital, Kamloops, B.C.

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**General Duty Nurses.** Salary: $173.23 (one hundred seventy-three dollars & twenty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day; 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

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**General Duty Nurses (2)** for 40-bed hospital on all-weather highway to Vancouver. 44-hr. wk. 28 days annual holiday plus 10 statutory holidays. Rotating shifts, annual increases & cumulative sick leave. Self-contained residence. Monthly salary: $220; full maintenance $45 per mo. Travelling expenses advanced if necessary. Apply Director of Nursing, General Hospital, Princeton, B.C.

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**General Duty Staff Nurses** for 515-bed General Hospital. 40-hr. wk. Beginning salary: $260 per mo. with advancement to $285; $20 additional for evenings & nights. Hospital & School of Nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

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**Graduate Nurses (3)** at once owing to present nursing staff leaving to get married. 30-bed hospital on C.P.R. main line & Trans-Canada Highway, 2 hrs. from Calgary. Modern nurses' residence & garage. 8-hr. day, 6-day wk. with rotating shifts. Starting salary: $170. $5.00 increase at end of each 6 mos. 3 wks. holiday & statutory holidays. Sick leave with pay & free hospitalization. Apply Matron, Municipal Hospital, Bassano, Alberta.

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**Graduate Floor Duty Nurses** for Mount Hamilton Hospital (Maternity), Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $100. For other perquisites & further information apply Supt.

## VANCOUVER GENERAL HOSPITAL

*The Vancouver General Hospital requires:*

***General Staff Nurses.*** 40-hr. week. Salary of $226.50 as minimum and $263.25 as maximum, plus shift differential for evening and night duty.

Residence accommodation is available.

Applications should be accompanied by letter of acceptance of registration in B.C. from *Registrar of Nurses, 1101 Vancouver Block, Vancouver 2, B.C.*

Apply to: **Personnel Dept., General Hospital, Vancouver 9, B.C.**

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**Graduate Nurses** for completely modern West Coast hospital. Salary: $230 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

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**Central Alberta Sanatorium, Calgary, Alta.,** offers to **Graduate Nurses** a 6-mo. postgraduate course in Tuberculosis. Maintenance & salary as for General Staff Nurses. Opportunity for permanent employment if desired. Spring & Fall Classes. Further information on request.

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**Nurses (1 or 2).** 24-bed hospital. Separate modern nurses' home. Salary: $190 per mo. plus full maintenance. Usual increases after 6 mos. Holidays, sick leave. Apply Matron, Union Hospital, Vanguard, Sask.

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**Director of Nursing & Principal of School of Nursing** for 375-bed General Hospital (with building program) in Southern Ontario. Comfortable suite in nurses' residence. Salary open. Apply, stating age, education, experience & other qualifications, together with recent photo, c/o Box B, The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

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**Instructor & Dietitian** immediately. Apply Prince County Hospital, Summerside, P.E.I.

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**General Duty Nurses** immediately for new 30-bed hospital. Holidays & sick leave according to R.N.A.B.C. Commencing salary: $220. Apply Matron, Valley Hospital, Creston, B.C.

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**General Duty Nurses** for 650-bed Teaching Hospital in Central California. Salary: $273-320 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market, Stockton, California.

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**Operating Room Scrub (Registered) Nurse.** Apply, giving experience, references, etc., Supt., The Cottage Hospital, Pembroke, Ont.

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**Associate Director** for School of Nursing with 90 students. Previous experience preferred. Duties to commence Aug. 2. Apply Director of Nursing, General Hospital, Oshawa, Ont.

---

**Operating Room** vacancies owing to expanded services in Plastic, Cardiac, Orthopedic & General Surgery. Apply Director of Nursing, Hospital for Sick Children, 555 University Ave., Toronto 2, Ont.

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**Registered Nurses (2)** immediately for 30-bed hospital within 1-hr. drive from Waterton National Park, ½-hr. from Lethbridge & 4 hrs. from Calgary & Great Falls, Montana. Salary: $175 per mo. plus full maintenance. Straight 8-hr. rotating shift. 44-hr. wk. 3 wks. vacation with pay after 1 yr. plus all statutory holidays. Apply Matron, Municipal Hospital, Magrath, Alta.

# POSITIONS VACANT

**Graduate Nurses (2)** for end of March. 50-bed hospital for Crippled Children on Vancouver Island near bus route, within easy driving distance of Victoria. Salary: $220 per mo. less $44 board & lodging. Single-room living accommodation in cottages adjacent to sea. Recreation available in tennis, swimming, boating & fishing. For further particulars apply, stating age & qualifications, Director of Nursing, Queen Alexandra Solarium for Crippled Children, Cobble Hill, B.C.

**Obstetrical Supervisor. Director of Nurse Education** (by May 15). Apply immediately, stating qualifications, Director of Nurses, Greater Niagara General Hospital, Niagara Falls, Ont.

**Laboratory Technician** with some knowledge of X-ray work or desire to learn for 38-bed hospital. Apply Supt., Joyce Memorial Hospital, Shawinigan Falls, Que.

**Public Health Nurse** (fully qualified) for Town of Strathroy. Salary: $2,400 per annum plus car allowance. Duties to commence as soon as possible. Mail applications to John Eakins, Sec., Board of Health, Strathroy, Ont.

**Registered Nurses** for new small hospital. Prevailing salaries with full maintenance provided. Attractive new residence adjacent to hospital. Straight 8-hr. duty, rotating shifts. 4 wks. vacation. 2 wks. sick leave. Apply Supt., Niagara Hospital, Niagara-on-the Lake, Ont.

**Science Instructor** for June or Sept. Complete maintenance in comfortable suite. 120-bed hospital — 35 students. New 150-bed hospital under construction. Apply, stating experience & salary expected, Director of Nurses, Jeffery Hale's Hospital, Quebec City, Quebec.

## Alberta

The following is news concerning the staff changes in the Alberta Division of Public Health Nursing:

**Appointments:** *Marguerite Boutry* (Holy Cross Hosp., Calgary) to Worsley; *Mrs. A. V. Johnson* to Tangent on completion of the obstetrics course; *Mary Molloy* (Prince Rupert (B.C.) Gen. Hosp. and University of Western Ontario) to Milk River; *Marion Roebuck* (St. Paul's Hosp., Saskatoon) to Hines Creek; *Ursula Weissbach* (Joyce Green Hosp., Dartmoor, Eng.) to Blueberry Mountain.

**Leave of Absence:** *Marjorie Mitchell.*

**Resignations:** *Wilma (Gunn) Bird* from Blueberry Mountain; *Mrs. V. Fadeeff* from Winfield for duty at Calgary General Hospital; *L. Hammett* from Hilda to serve with Sturgeon health unit, Westlock; *Mrs. Eulodie Key* from Vauxhall; *Mrs. Lois Laycraft* from Hines Creek; *Theresa Lynch* from Milk River to return to Ontario; *Lillian Tweedy* from Wainwright school division to join staff of Minburn-Vermilion health unit.

*Edna (Drake) Hunter* has opened a new district at Tomahawk, 70 miles west of Edmonton.

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Statisticians say the average person gets 2 and 1/3 colds a year. But statistics don't measure the thousands of man-hours lost to industry, the complications, the miseries of the sufferer. Cold cures? There are none, once the virus takes hold. But departments of health cite preventive measures that *cut down* cold attacks — and severity: Eat a well balanced diet; include fresh fruit, citrus fruits particularly. Drink lots of water; avoid chills; don't share drinking glasses with family members who have colds. If you have *fever* — call *a doctor.*

The everyday management of a large ward, let alone of a hospital — the knowing what are the laws of life and death for men, and what the laws of health for wards — (and wards are healthy or unhealthy, mainly according to the knowledge or ignorance of the nurse) — are not these matters of sufficient importance and difficulty to require learning by experience and careful enquiry, just as much as any other art? They do not come by inspiration to the lady disappointed in love, nor to the poor workhouse drudge hard up for a livelihood. — F. NIGHTINGALE